CUMBERLAND COUNTY COUNCIL
EDUCATION COMMITTEE

The School Health Service

1963

JOHN LEIPER
PRINCIPAL SCHOOL MEDICAL OFFICER

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INDEX

PREFACE

To the Chairman and Members of the Education Committee:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1963.

A high standard of general health of school children has been maintained during the year and the number of children reported as being unsatisfactory at medical examination is very small.

The main progress in the School Health Service during the year has been the extremely successful initiation in the southern area of a system of selective medical inspection. This system represents an up to date, modern and progressive outlook on medical examination of school children, and fits in well with the generalised pattern of selective screening and the follow-up of the "At Risk" children originally notified shortly after birth.

Other sound progress has been made in the administrative sphere where a system of area administration for all health, school health and welfare functions is being set up in three areas, each with a total population of nearly 75,000. Matters of policy and finance will still be dealt with centrally and the remaining central Sub-Committee, the Joint Sub (Health and Education) Committee, remains as an even more important Committee to which a wide range of health, welfare and education matters are expected to be put in the near future.

The County has always been proud of its School Dental Service and recently even further improvement has been made in the Service by the modernisation of the dental clinic facilities and also by the extremely successful co-operation with the Hospital Board's Consultant Orthodontist in arranging for every Dental Officer to have a course on orthodontics over a period of three months. This course proved most stimulating and exciting to the Dental Officers who have now gained much knowledge and experience so that a wider range of orthodontic treatment can now be carried out by the School Dental Service in co-ordination with the Hospital Dental Service and Consultant Orthodontist.

Handicapped pupils continue rightly to occupy a great deal of the time of the School Medical Officer and during the year a start has been made with case conferences on school leavers carried out on an area basis in order to ensure as far as possible as easy a transition as possible from the school to the adult situation. This case conference started originally with the deaf, of whose welfare in this County we can be justifiably proud.

The early ascertainment of partial hearing or deafness has proceeded apace and audiology teams including an Audiometrician and the Peripatetic Teacher of the Deaf, together with the School Medical Officer and the Otologist have been extremely successful, although one always feels that there is a great tendency for the Hospital and Education Authorities to duplicate facilities in respect of school children.

Lastly, the Educationally Sub-normal school leaver who is always a potential hazard case, has received a great deal more attention from the School Nurse, School Doctor and Social Workers with the advice of the teachers, and indeed some Educationally Sub-normal school leavers have already attended the Adult Training Centre in West Cumberland.

The slow recognition by all groups that cigarette smoking has a costly effect in the production of ill health has been underlined by the wide use of the film " Smoking and You " in the schools generally, and it is a sombre thought to realise that the deaths in the County from lung cancer continue to rise.

The staff continue to provide a very efficient and well run Service, although there have been difficulties in obtaining the services of speech therapists and orthoptists during the year. I hope these difficulties can be overcome in the near future.

The Gillie Report on " The Field of Work of the Family Doctor " is reflected in the appointment during the year of Dr. Ainsworth as an Assistant School Medical Officer having previously worked in general practice. Mr. Green has also joined us during the year as dental officer following the departure of Mr. Macdonald to Africa.

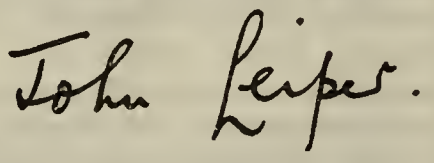
From colleagues in general and hospital practice, I have once again received much co-operation, and value increasingly the link that has been operated with Dr. Platt, Consultant Paediatrician. It is hoped during the next year that the

Hospital Board will have appointed a Paediatrician for East Cumberland and that further great progress can then be made.

I wish lastly to thank all who helped with the preparation of this report, especially my Deputy, Dr. J. D. Terrell. The high standard of work of all members of the Health Department has continued to be invaluable.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant,



Principal School Medical Officer.

County Health Department,
11 Portland Square,
Carlisle.
May, 1964.

SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.63

SCHOOL MEDICAL AND DENTAL STAFF

Principal School Medical Officer—

*J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy Principal School Medical Officer—

*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

School Medical Officers—

A. Crowley, M.B., B.Ch., D.Obst.R.C.O.G., D.P.H.
*J. N. Dobson, M.B., Ch.B., D.P.H.
J. R. Hassan, M.B., Ch.B., D.Obst.R.C.O.G. (Part-time—General Practitioner).
*J. L. Hunter, M.B., Ch.B., D.P.H. (Senior Assistant School Medical Officer).
*J. Patterson, M.B., B.Ch., B.A.O., D.P.H.
*H. C. T. Smith, M.B., Ch.B., D.P.H., D.P.A.
*K. J. Thomson, M.B., Ch.B., D.P.H., L.M.

The above are also District Medical Officers of Health and Assistant School Medical Officers.

J. E. Ainsworth, M.B., Ch.B. Commenced 30.9.63.
*E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. & H.
*C. H. Mair, L.R.C.P., L.R.C.S. (Ed.), D.P.H. Resigned 21.6.63.
*E M. Spencer, M.B., Ch.B.
*M. Timperley, M.B., Ch.B.

*Approved for the ascertainment of educationally subnormal pupils.

Principal School Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area School Dental Officer—

R. C. Crabb, L.D.S.R.F.P.S.

School Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S
M. Green, L.D.S.R.C.S. Commenced 1.1.64.
D. H. Hayes, L.D.S.
M. Hayes, B.D.S.
F. H. Jacobs, L.D.S.
A. MacDonald, L.D.S. Resigned 2.11.63.
I. H. Parsons, L.D.S.
A. R. Peck, L.D.S.
J. G. Potter, L.D.S.R.F.P.S.
A. M. Scott, L.D.S.

MEDICAL AUXILIARY STAFF

Audiometricians—

Mrs. M. G. Hicks.
Mrs. R. Gaughy.

Orthopaedic Physiotherapists—

Miss J. A. Fraser, M.C.S.P., O.N.C.
Miss J. M. Morris, M.C.S.P.

Orthoptists—

Mrs. S. Richardson, D.B.O. (Part-time). Resigned 31.7.63.
Mrs. G. M. Richardson, D.B.O. (Part-time). Commenced 21.10.63.

Speech Therapists—

Miss C. M. Allan, L.C.S.T. Resigned 31.2.63.
Mrs. E. M. Blacklock, L.C.S.T.
Miss E. B. Moon, L.C.S.T.
Mrs. S. Latimer, L.C.S.T. (Part-time). Commenced 30.4.63.
Mrs. M. V. Aitchison, L.C.S.T. (Part-time). Commenced 5.11.63.

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V.Cert.

Assistant Superintendent Nursing Officers—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert. Commenced 1.8.63.

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert., P.H. Admin. Cert. Resigned 30.6.63.

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert., R.F.N.

NURSES QUALIFICATIONS CODE

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitors Certificate.
5. Registered Fever Nurse.
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

School Nurses—

Full-time—

Mrs. E. M. Maguire, 1, 2, 8	Whitehaven
Mrs. M. E. Sansom, 1, 2, 5	Relief
Mrs. B. F. Wilson, 1	Whitehaven
Mrs. M. K. Wilson, 1	Relief
Miss D. Wise, 1, 2, 3, 5, 9	Workington

Health Visitors/School Nurses—

EAST CUMBERLAND

Miss A. Dixon, 1, 2, 4	Penrith
Miss B. W. Knibbs, 1, 2, 3, 4	Brampton
Mrs. A. W. E. Maughan, 1, 2, 4	Longtown
Mrs. M. McCredie, 1, 2, 4	Penrith
Miss E. Mercer, 1, 2, 4, 5	Wigton & Silloth
Mrs. M. C. Roberts, 1, 2, 4	Aspatria

WEST CUMBERLAND

Miss G. Davies, 1, 3, 4	Workington
Mrs. B. L. Goodson, 1, 2, 4	Workington
Mrs. M. Hewitson, 1, 2, 4	Workington
Miss M. McCann, 1, 2, 3, 4	Workington
Miss J. E. Surtees, 1, 2, 4	Workington

SOUTH CUMBERLAND

Miss I. M. Alcock, 1, 2, 4	Whitehaven
Mrs. S. Bowe, 1, 2, 4	Whitehaven
Miss E. Crosby, 1, 2, 4	Egremont
Miss A. M. Greggain, 1, 2, 3, 4	Cleator Moor
Miss R. A. Lodge, 1, 2, 4	Whitehaven
Mrs. A. Petch, 1, 2, 3, 4	Whitehaven
Miss R. Sheppard, 1, 2, 3, 4	Cleator Moor
Miss P. Walsh, 1, 2, 4	Egremont

All the above health visitors/school nurses are seconded to general practitioners.

School Nurses—

Part-time—

EAST CUMBERLAND

Miss I. Arnott, 1, 2, 3, 8	Threlkeld
Miss M. A. Barclay, 1, 2, 3, 5	Greystoke
Mrs. E. C. Barnes, 2, 6	Lanercost
Miss A. Bowler, 1, 2, 3, 4	Caldbeck
Miss J. R. N. Byres, 1, 2, 3, 5	High Hesket
Miss E. M. Chalkley, 1, 2, 3	Langwathby
Miss A. A. Cockton, 1, 2, 3, 5	Burgh-by-Sands
Mrs. M. Dobson, 1, 2, 3, 4	Houghton
Miss L. R. Douglass, 2, 6	Skelton
Mrs. F. A. Gaskin, 1, 2, 3	Irthington
Miss C. H. Greaves, 1, 2, 3	Lazonby
Mrs. M. Hedworth, 1, 2, 3	Abbeytown
Miss E. Henderson, 1, 2, 3	Langwathby
Mrs. D. M. Lancaster, 1, 2, 3, 4	Wigton
Mrs. M. J. Mathews, 1, 2, 3, 4	Watermillock
Miss F. M. McGrath, 1, 2, 3	Dalston
Miss A. M. M. Penman, 1, 2, 3, 4	Thursby
Mrs. E. E. Rome, 2, 6	Kirkbride
Mrs. M. Sanderson, 1, 2, 3, 4	Alston
Miss N. D. Sanderson, 1, 2, 3, 4	Bewcastle
Miss P. B. Simpson, 1, 2, 3, 4	Wigton
Miss E. M. Wallace, 1, 2, 3	Wetheral
Miss M. Weightman, 1, 2, 3	Scotby
Miss B. M. Wesson, 1, 2, 3	Hayton

WEST CUMBERLAND

Mrs. C. Butcher, M.B.E., 1, 2, 3, 5	Bassenthwaite
Miss M. Casey, 1, 2, 3, 4	Keswick
Mrs. A. Donald, 1, 2, 3, 4, 7	Oughterside
Miss S. J. Graham, 2, 6	Brigham

Mrs. M. Hall, 2, 6	Relief
Miss M. Horn, 1, 2, 4, 5	Cockermouth
Miss J. M. Hillhouse, 1, 2	Keswick
Miss R. Hobbiss, 1, 2, 3, 4	Lorton
Mrs. N. Hodgson, 2, 6	Broughton
Miss S. M. J. Iliffe, 1, 2, 3	Borrowdale
Miss F. Kendall, 1, 2, 4	Maryport
Miss C. F. M. McKnight, 1, 2, 3, 4	Dearham
Miss S. Twigg, 1, 2, 3, 4	Maryport
Miss R. W. Ventress, 1, 2, 3, 4	Bothel

SOUTH CUMBERLAND

Mrs. I. E. Bowe, 1, 2, 3, 4	Bootle
Mrs. J. A. Graham, 1, 2, 3, 4	Distington
Mrs. J. A. G. Hardie, 1, 2, 3, 4	Parton
Miss D. D. James, 1, 2, 3, 4	Seascale
Miss A. M. Little, 1, 2, 4	Millom
Mrs. M. Marshall, 1, 2, 3	Muncaster
Miss A. M. Mackay, 1, 2, 3, 4	Lamplugh

Dental Surgery Assistants—

Mrs. G. M. Barlow	Mrs. S. F. Kerr
Miss O. Bird	Mrs. J. G. Nicholson
Mrs. M. Byers	Mrs. W. F. Reeves
Miss J. E. Harrison	Mrs. B. H. Robinson
Mrs. E. Hocking	Mrs. C. Smart

Miss M. I. Stout

GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1963, was 224,630.

The number of pupils on the school registers in January, 1964, was 38,405, compared with 37,768 in the previous year, an increase of 637.

In January, 1964, there were in the county:—

		No. of pupils
Nursery school	1	40
Primary schools	244	22,751
Non-selective secondary schools	24	9,981
Grammar schools	9	5,206
Secondary Technical Schools	1	332
Residential special schools	2	
(One for educationally subnormal boys, age range 9-16 years)		57
(One for educationally subnormal girls, age range 9-16 years)		38
		38,405

THE PATTERN OF THE SERVICE

I outlined briefly last year the development of the School Health Service which has led to the concept of selective medical examination of school children, rather than comprehensive screening at arbitrarily fixed points in school life. As envisaged in that report, the new arrangement for selective medical examinations in the southern area of the county, came into operation from the beginning of the summer term. I include in this report the impressions of the doctors who have so far taken part in this scheme. They confirm, I believe, the soundness of the general concept, while at the same time indicating the difficulties encountered — many of which were anticipated in greater or lesser degree — and how they are being tackled.

This approach to the health screening of school children fits an up to date pattern of concentration on " risk " groups and, indeed, links up with increasing accuracy with the " At Risk " register now growing in the department from data on events at birth and in early childhood. A parallel register of congenital abnormalities was begun in January of 1963 in response to a request from the Ministry of Health. This recording of congenital abnormalities has, at the end of the year, been systematised by the Ministry of Health, and hospital medical staffs as well as general practitioners are co-operating in the collection of this data, which will be processed and studied by the Registrar General. As has repeatedly been pointed out in connection with these registers, they concern closely many handicapped school children of the future.

The other most important aspect of planning in 1963 has been the preparation for a system of area administration of the Health and Welfare Services, including in large measure the School Health Service. This reorganisation of the administration will become effective in the summer of 1964, and will vest the responsibility for most of the day to day running of the School Health Service in three Area Health and Welfare committees, to each of which an Area Medical Officer will be responsible for executive action, assisted by an Area Nursing Officer and an appropriate staff. The membership of these Area Health and Welfare Committees will be strengthened by the presence on them of the teacher representatives of the corresponding Area Education Committees. In addition to this main

committee reconstruction the Joint Sub (Health and Education) Committee will be similarly strengthened by the presence of one teacher representative from each Area Education Committee and will meet at least twice per year to consider *inter alia* the more important matters of policy in the development of the School Health Service, as well as to appoint such members of staff as dental officers, speech therapists, etc. Reporting to both Health and Education Committees, the reconstructed Joint Sub (Health and Education) Committee should play, in my opinion, an increasingly important rôle in the School Health Service in guiding policy and forward thought. The aims and purposes of education and community health are, I believe, converging more and more and in this conviction I know that Mr. Bessey, the Director of Education, concurs. From infancy to old age the parts to be played by health services on the one hand, and education services on the other, relate to each other increasingly closely and I look forward to the joint committee exploring this matter helpfully.

Medical Examination of School Children

Although the emphasis of the school medical officer and school nurses' work must inevitably shift still further towards health education and the care of the special group of handicapped children, at least for some time to come the larger part of the medical officer's time will be spent on the interviewing and examination of school children, wherever possible accompanied by a parent.

The selective type of medical inspection in the southern area was in operation during the summer and autumn terms of 1963. Dr. Dobson and Dr. Spencer in the Whitehaven and Ennerdale areas, and Dr. Crowley in the Seascale and Millom areas undertook this major reorientation of the " routine " work of medical examination supported by a keen band of school nurses. Without a full year of the scheme having passed it is difficult to assess it comprehensively, and the statistics with regard to numbers of those examined found to have defects, etc., is inevitably " mixed " for the year. I think it is best at this stage to allow these doctors themselves to speak for the new approach and discuss their impressions and thoughts for the future. Dr. Dobson writes as follows:—

" The changing approach to school medical inspection was described by the Principal School Medical Officer in his Annual

Report on the School Health Service, 1962. The current aim in Cumberland, to describe it as briefly as possible, is to retain universal examination of pupils on school entry and prior to leaving school, while examining only a proportion of the middle age groups. Those selected for examination at 8 or 12 years are picked out on the basis of information supplied by parent, school nurse or head teacher, time saved on the old system being used to give more attention to those examined under the new.

" There can be no improvement in the service if selection is poorly done, and so far the Ministry of Education has given wide latitude to authorities to use their own initiative in choice of method. In the planning stage a study was made of the methods used by the few authorities who had already embarked on similar schemes, and discussions took place with the county's school medical officers. A start was made with the new system in the southern area in the summer term, 1963, the head teachers having first had it explained to them in co-operation with the Education Department. Not only was it hoped to make more use of the teachers' knowledge of their pupils but to make the necessary termly visit more helpful to staff as well as children.

" The pre-inspection discussion between medical officer and head teacher is an essential part of the scheme. Medical histories of their children supplied by parents are not, of course, discussed, but the contributions of school staffs on educational and behaviour problems are invaluable, as their observations frequently are on a pupil's failure to play games or participate in P.E. At times this is supplemented by a wealth of information about the child's brothers and sisters, parents, grandparents and cousins, which would surprise some parents, more especially the indifferent. Such parents are usually among those who give their children a clean bill of health, and thus may wittingly or unwittingly evade medical inspection. As a rule the real problem family is already known to the doctor, nurse and teacher, but above this level are those children in whom detection of the need for examination, and hence of any medical reason for failure to progress in school, is not always easy.

" Fortunately those important causes of poor progress, defective vision or hearing, are now less likely to be missed

with the introduction of eye-testing at school entry and the development of routine audiometry, while a number of other defects come to light at the first periodic inspection. Unless there is frank mental subnormality, however, backwardness, whether innate, or the cause or consequence of a variety of difficulties, is not readily detectable at routine inspection. Even if it is suspected, the extent of its effect on learning is unpredictable. It is desirable that such children should be picked up as early in school life as possible, for some have sufficient attainment to steer them clear of the educational psychologist's intelligence checks. A satisfactory system of selection, and adequate time to investigate such children, are essential if conditions producing no immediately identifiable picture are not to be overlooked.

" Once it has been decided there is reason to examine a child it may be necessary to go further into the medical background with the parents. Such matters as lengthy illnesses or spells in hospital or the after effects of neurological disease are plainly relevant to child development, but so may be the antenatal and family history. They may shed light on easily missed conditions such as partial epilepsy, or minimal degrees of cerebral palsy, which can be responsible for inexplicable delay in learning to read; or emotional problems which have the same result may emerge in the discussion.

" In the course of two terms' experience of selective medical inspection a number of its advantages have been readily confirmed, as Dr. Spencer testifies elsewhere in this report. But they do not include full realisation of the aims outlined for at least two reasons, one of which is unsatisfactory completion of the medical history forms sent to parents. At one large junior school for example, 45% of the forms recorded no complaints at all, whether past or present; it is hard to believe that nearly half the 8 year olds have never given their parents cause to query their health or progress. This moderate response was attributed at least in part to the form in use being unduly lengthy and complicated. Accordingly it has been simplified and the new form is presently being given a trial.

" The other reason is the still inadequate time available for selective inspection. Ideally no more than perhaps fifteen pupils should be examined in a session. The substitution of selective inspection in two age groups, 8 and 12, for the single periodic

examination at age 10-11 has so far resulted in no saving in time, and too many pupils have to be seen if inspection schedules are to be maintained.

" Nevertheless there is welcome new scope in selective medical inspection. With the adaptations dictated by growing experience selective inspection should prove to be a substantial advance on any previous plan for care of the health of the school child."

Dr. Spencer's comments below are complementary in an interesting way to the above:—

" It is rather difficult to assess the results but I feel that there were a number of advantages. There seemed to emerge a closer contact and better relationship with the teaching staff and there was the opportunity to observe and/or examine a child once a term when worried about his welfare. The parents seemed to come to the school medical inspection more readily, and the short appointment forms just requesting the presence of a parent were very useful in bringing a parent (say the following day) if one specially wanted to see her. This was especially useful if the teacher brought forward a child during the course of the inspection.

" I seemed to select and see about half of any group of children given questionnaires but a large number of those selected had nothing wrong, and a new questionnaire to try to get a more accurate idea of those children in need of attention is receiving a trial.

" If the parents do not complete a questionnaire I see the child, but if they do not complete it accurately, e.g., just sign it and return it, then there is a possibility of a neglected child not being seen unless the head teacher brings him forward. Similarly, those diseases of the middle of school life, e.g., rheumatic heart disease, slipped epiphysis, emotional stress of the 10-11 year examinations may be missed.

" The administration of the scheme as I ask for it to be done is rather difficult as it involves splitting the still routine parts (entrant and leaver) of the school medical inspection into three parts.

" Sometimes it is difficult to convince parents that their child has not been selected; they are so used to the children being examined whenever a questionnaire is sent home.

" The ages at which selective examinations are conducted using the questionnaire could, perhaps, be revised. They are when the child is in the 5th, 8th, 12th and 14th year. The largest gap in time is likely to occur when the child is 8-12 years old, just at the time when it becomes apparent if he is not learning well and when more frequent examinations might be profitable. At the other end, when the child is approaching school leaving age, he has the opportunity of being examined twice at a very short interval. At this stage in his school career, most defects will have been diagnosed and there is not much time left at school if some important discovery is made.

" On the whole I find that I prefer the new scheme. I am sure that adjustments can be made to solve the difficulties and, while one cannot satisfactorily compare the numbers of defects found in this and the previous schemes, if the teachers and nursing staff continue to refer any child they are anxious about, I think that the new scheme should work very well."

From Millom Dr. Crowley writes the following:—

" In this area a change over to the new selective method of medical inspection was carried out in the spring of 1963. Thus, in that year, some were examined in the old way and some in the new. Initially misgivings were felt in the change over; it was a rather more complicated method. First a questionnaire was sent out to parents in all groups to be screened, then an initial visit was made to the school by the school doctor and school nurse. At that visit after consultation with the teacher and taking into account the answers to the questionnaires, pupils for medical examination from the intermediate groups were chosen. A date and time for the medical inspection was then arranged. As three people, all of whom have other jobs to perform, were concerned in this arrangement it was not always easy to arrive at a suitable date. However, no insuperable difficulties were experienced and the medical examinations were carried out satisfactorily. In some cases the teacher put forward children for examination who were not of those groups and these children were examined when considered necessary. Routine annual vision tests were also carried out for all children.

" All in all it was found that the new system is a success. This was especially so in the bigger schools, where the time saved by the exclusion of healthy intermediate pupils could be

spent on those requiring medical assessment. In the smaller country schools, however, this was not found to be the case. The trouble in arranging an initial visit was often not worthwhile. Sometimes in these cases there might be less than six intermediate pupils from which to make selection. In such a case a whole session might be devoted to very little purpose."

Various thoughts emerge and questions are raised by these accounts and comments. For example, a study of local and national figures of numbers of children found on examination to have defects requiring treatment shows that as many (and often more) 15 year olds show such defects as do school entrant children. Is the assumption, therefore, necessarily justified that it is the entrant group who should all be routinely examined while the older groups can be " selected." I believe the principle of selection to be correct but, perhaps, it is equally justifiable for the school entrant group? I hope the statistics of the new scheme next year may give a clue on some such questions.

Year	Total Periodic Examinations	Total Pupils found to have Defects	%		Total found with unsatisfactory physical condition	%	
1963	8,865	871	9.8		6	0.07	
1962	12,547	1,078	8.5		2	0.02	
1961	8,754	715	8.2	(15.51)	9	0.10	(0.68)
1960	9,633	915	9.5	(15.99)	50	0.51	(0.85)
1959	9,985	1,072	10.7	(15.76)	71	0.71	(1.14)
1958	10,887	1,286	11.8		97	0.89	
1957	10,864	1,302	11.9	(14.98)	132	1.22	(1.72)
1956	9,783	1,352	13.8		247	2.52	

The figures shown in brackets are the available comparative figures for England and Wales.

Examination Findings, 1963

It will be apparent from the above reports and table that the total number of medical examinations carried out in 1963 is a " mixed " one, in the sense that the number 8,865 contains those examined by selection in the southern area along with the " periodic " examinations throughout the county. The

reduction in the total figure from that for 1962 is mainly accounted for by the selection procedure in the intermediate age ranges in the southern area and, to a lesser extent, to some necessary curtailment of school visits due to staff illness. It is really too early to say whether the slightly increased proportion showing defects is, in fact, related to the selective procedure in South Cumberland and the numbers written down as " unsatisfactory " are not significant, although a few more than last year.

I am very glad to quote the following comments by Dr. Ainsworth who joined the staff as a School Medical Officer during 1963, having previously been engaged in general practice in West Cumberland:—

" I have only a limited experience so far in the School Health Service, but I have been impressed by two factors. 1. The absence of major disease. On the whole the children are well developed, well nourished, clean and can express themselves well. They are less shy and many know what they want in life and what they hope to do. I must also mention the excellent condition of their teeth on the whole. 2. A certain amount of overlap with the general practitioners. After being a general practitioner for several years I noticed this but it is difficult to visualise a satisfactory alternative to the School Health Service. It is only by some arrangement for seeing the children that one knows what has happened to them and many minor defects are found which would not either be seen by, or brought to the notice of, the family doctor, e.g., visual, minor orthopaedic and cardiac lesions especially. Certain physically handicapped pupils particularly interested me."

The secondment of health visitors/school nurses to general practitioners in 1963 has advanced to the stage where all but two of the full-time health visitors are seconded to group practices involving a total of 64 general practitioners. In most cases this arrangement substantially benefits the school health component of the nurse's work; in others the arrangement has proved a little disappointing in this respect. Where this occurs it is purely because of family patterns and school situations, so that, while a health visitor/school nurse is the family nurse-social worker attached to that family's doctor, it is not always possible for her to have direct contact with say three different schools being used by the children. Having said this, however,

I have still no doubt that, even in these situations where there must be a " two-stage " liaison on school situations with the general practitioner, the direct attachment and regular contact through one nurse is a material advantage.

There is still some advantage in having a small number of full-time school nurses in Whitehaven and Workington. Ultimately, I feel the future holds a complete integration of health visitor and school nurse work which would be more in keeping with the now established principle of secondment to family doctors. The full-time school nurses, meantime, continue to do a first class job and I am glad to quote two of them this year. Miss Maguire writes as follows, herself indicating the advantages of the health visitor:—

" School nursing plays an important part in the health service. Having nearly completed four years in this service, I find I am now recognising in the school entrants those children whom I first encountered as toddlers while helping in the child welfare clinic. This gives an added advantage when it is necessary for some reason to visit the parent, as one feels the ice is already broken and one is not approaching a complete stranger. This is where the health visitor has an advantage over the school nurse as she has already visited most of the mothers and knows them better."

Miss McCallum writes:—

" School nursing work, as it deals with young people, must be important. With a few exceptions I find the standard of cleanliness is very high. Most children appear well nourished and beautifully clothed and have a pride in their teeth. I marvel at the confidence of new entrants, it is surprising how quickly they establish themselves into school life."

In the matter of liaison between school and home, the school nurse/health visitor is in a position of supreme advantage, in many cases having a free access as trusted adviser on family health matters. On this Miss Wise comments: " I have no difficulty when visiting the homes. Mothers have always been willing to co-operate and listen to advice, and also come to the clinic if they have any further problems. Home visits are most important. The mothers get to know who the school nurse really is and what she is doing."

Hygiene Inspection

I emphasised last year that the school nurse's termly visit to schools to make a hygiene inspection involved much more than the examination of heads for infestation; and also that these visits were to form the basis of the selective medical inspection in the southern area.

It will already have been seen from the doctors' reports that this latter aim was only partly realised in that the synchronisation of school nurse, school medical officer and head teacher time each term to constitute a selection conference, often proved beyond the possible for all concerned. It, nevertheless, plays, and will continue to play, an important rôle in the selection procedure. With regard to the content of the hygiene inspection, while all the other elements continue to receive due attention, particular emphasis was, in fact, given in 1963 to the specific matter of head infestation, and this despite a very heavy programme of immunisation work which is reflected in the figures shown in that section. The concentration on head cleanliness was required, of course, by the rising numbers of children in 1962 found infested, and the figure, as will be seen, is almost identical for 1963. That this constitutes a singularly difficult problem is evidenced by the fact that, although much additional time was given to this work (95,817 examinations compared with 69,439 in 1962) the number found infested is practically unchanged. I feel confident that one thing which this means is that very few cases indeed are being missed in school and the frequent examinations ensure that cases are cleared very quickly. Re-infestations at home remain a central problem which only too often becomes a " treadmill " experience to the nurse. Mrs. Wilson, school nurse, working from Flatt Walks Clinic, Whitehaven, writes on this subject:—

" At the beginning of each new term a full cleanliness inspection is carried out in the schools, and as far as possible this is followed up by weekly re-inspections. I find it beneficial to inspect classes of pupils, rather than only those found to have ' nits ' on a previous visit. The children who have verminous heads (especially those between the ages of 9 and 15 years) appreciate this, and it does encourage them to make an effort to clean their hair, and to keep it clean. Frequent talks are given in schools about ' The Care of the Hair,'

'Infestation and Treatment,' and 'Personal Hygiene.' Individual talks are also given during re-inspections. Special clinics are held at the clinic for secondary modern pupils, and although few children attend these a few seem to enjoy the talks, and put into practice what has been discussed. Weekly home visits, where necessary, in most cases encourage the parents to look after their children's hair and clothing. Shampoo or lotion is given to the parents during these visits and every effort is made to be helpful and kind to parents and children. I find the majority of parents in this area realise that the school nurse is trying to be helpful, and that she is really interested in the children. Regarding treatment; meantime in this area Lorexane lotion and Lorexane shampoo is issued where necessary. Steel combs may be obtained from the clinic by the parents. Where a parent is unsuccessful in cleaning the children's hair, these children attend the clinic to have their heads cleansed by nurse."

Year	No. of examinations	No. of children found infested
1963	95,817	1,419
1962	69,439	1,406
1961	79,007	1,269
1960	72,226	1,531
1959	86,790	998

Miss Maguire's comments underline the extremely important Health Education aspects of this subject:—

"It is also invaluable to have good co-operation with the teaching staff of the schools, particularly the head teacher, as this is most helpful especially when dealing with cleanliness in children. During the past few months I have been able to do more intensive work in connection with head infestation and I feel the result of this is shown in the reduced number of names appearing on the quarterly report. One trusts that this will be maintained, as due to pressure of school medical inspections it will obviously not be possible to carry out quite so much work in this line, but this should not be necessary if the talks that have been given have really been understood and appreciated, as they appear to have been at the present."

A curious comment made last year by one of the nurses in the context of hygiene inspections is as follows:—

"A little here about schools. I was amazed to find during

my work assisting at ear, nose and throat clinics and at school medical inspections, how many children could not blow their noses. I now find handkerchief drill with the use of paper handkerchiefs a must at the beginning of cleanliness inspections in the infant schools."

On only one occasion was a Section 54 compulsory notice issued during the year, and in that case not beyond the early stage of a " cleansing notice."

Indeed the opportunities for health education in connection with hygiene inspections are legion and are widely exploited by the nurses at both group and individual level.

Employment of Children Bye-Laws.

The figures below show the numbers of children examined during the year in accordance with the above bye-laws. None of the children examined were found to be unsatisfactory.

Total examined during the year	286
Total number of children involved ...	257

Examined for first time	Re-examined once	Re-examined twice
220	41	25

School Clinic Work

The new arrangement described last year whereby formal school clinic sessions were discontinued except at Whitehaven and Workington, has worked satisfactorily during the year. The freedom to refer school children to any child welfare clinic before or after the main clinic session, in fact, increased the number of locations for such special consultations from 17 to 28. At the same time school time is saved for the children concerned and the family doctor's position is safeguarded in the matter of treatment.

It will be seen from the figures given that the attendances at " school clinics " has diminished substantially. This was to be expected in that the new arrangement makes for much more selective visiting of actual clinic premises and more advisory care by nurse and doctor in the school. As indicated in other parts of this report the secondment of nursing staff to general practices and the introduction of selective medical examinations have an important bearing on clinic work. Furthermore, it is clear that the present arrangement need not adversely affect the immunisation and vaccination figures for school children. These are up this year because of increased work in the schools.

The opening of the new clinic at Seascale on 2nd May vastly improved the provision in this developing area for all clinic purposes, including dentistry. The association with a new library is, I think, a very neat and significant indication of the developing links between health and education to which I have already referred. Both parts of the building shared the same " open day " and it was fascinating to observe the pleasing number of people who visited the building, passing from library to clinic and vice versa. A branch of the library in the dental suite was even suggested!

Salterbeck clinic, similar in design to the clinic wing of the Seascale building, should be completed by the time this report is published. It, too, will serve an expanding residential area—this time of Workington, and at the same time replace one clinic at present being held in unsatisfactory church hall premises. Further new clinics are planned for Cleator Moor in the years 1964/65; for Maryport and Longtown in 1965/66; and for Cockermouth in the following year. Also later in the current ten-year programme are clinics at Frizington, Brampton, Tarraby, Seaton, Keswick and Moorclose (Workington).

Clinic	New Cases	Total Attend-ances
Anthorn	3	3
Aspatria	53	143
Brampton	30	48
Cleator Moor	29	49
Cockermouth	93	132
Frizington	5	6
Houghton	7	7
Keswick	32	33
Longtown	3	3
Maryport	27	64
Millom	37	70
Penrith	13	14
Scotby	2	2
Wetheral	1	1
Whitehaven (Mirehouse)	20	23
Whitehaven (Flatt Walks)	118	222
Whitehaven (Woodhouse)	3	6
Wigton	38	41
Workington	160	380
	674	1247

SCHOOL CLINICS

Defect Code No.	Conditions for which child attended	New Cases						Total Attendances					
		1963	1962	1961	1960	1959	1958	1963	1962	1961	1960	1959	1958
1.	Cleanliness	11	—	1	5	1	5	16	—	7	16	6	11
2.	Infestation	2	—	6	51	38	73	2	—	13	126	146	219
4.	Skin diseases	147	597	524	827	628	508	408	1891	1867	2906	2448	2092
5.	Eye diseases	169	303	298	270	352	380	316	729	698	855	1109	1237
6.	Ear conditions	78	64	63	72	99	105	105	213	233	247	356	316
7.	Nose and throat conditions	44	50	37	55	78	124	68	80	77	128	143	205
8.	Speech defects	21	34	22	25	20	31	22	43	26	34	25	44
9.	Lymphatic glands	3	16	3	3	6	3	4	21	7	5	10	18
10.	Heart	3	2	2	5	4	1	3	11	4	17	10	3
11.	Lungs	18	37	23	21	44	53	26	358	51	97	232	216
12.	Developmental	2	6	2	1	3	—	5	13	8	9	7	1
13.	Orthopaedic	46	105	35	84	110	101	48	165	54	132	196	194
14.	Nervous system	2	5	7	19	24	10	3	32	12	256	156	62
15.	Psychological	12	25	16	15	16	27	17	45	29	34	35	51
16.	Abdomen	13	15	5	17	6	23	16	25	8	40	16	44
17.	Other conditions	103	244	356	732	735	909	188	541	856	1826	1828	2867
		674	1503	1400	2202	2164	2353	1247	4167	3950	6728	6723	7580

SPECIAL SERVICES

A full range of specialist clinics continues to be provided under the auspices of the School Health Service and staffed by consultants from the Regional Hospital Board. I am indebted to some of these specialists for comments which I quote below on the services which they provide.

Ear, Nose and Throat Conditions

Clinics are held in Carlisle and Whitehaven as required. Mr. Thomas has kindly contributed to the report this year on audiology and E.N.T. services in the area generally. Writing from the hospital specialist's point of view he offers a stimulating and comprehensive solution on audiology. The report which follows from both East and West Cumberland on audiology work with children carried out by the school health and child welfare services, is, I think it will be agreed, very creditable in itself as a going concern, and readily capable of being the nucleus of any more comprehensive and ambitious audiology service such as Mr. Thomas envisages. This audiology work in schools and clinics has proved both well worthwhile and time consuming. The latter factor has, unfortunately, got rather in the way of some of the interesting research projects which Mr. Thomas also suggests in the E.N.T. field, but these are highly valued and will receive further consideration.

Mr. Thomas writes as follows:—

"The outstanding success in the detection and prevention of illness by the Public Health Authorities cannot lead to complacency. Progress must not be hindered by cumbersome administration.

Audiology Clinics

"The Ministry of Health [H.M.61 (89), 23/61] recommended these; but said they should be provided either by the local authorities or by the hospital service. The E.N.T. department in Carlisle is a single unit serving a population of nearly half a million, covering the geographical area from Stranraer to Millom. There are at least six local authorities in this area. In this case it seems obvious that the hospital service should be responsible and an audiology clinic (for all ages) should be set up in Carlisle with associated clinics in Dumfries and West Cumberland.

" Since the Ministry cannot decide who will provide the clinics progress has been slow: the patients, young and old, continue to get adequate treatment as before. There is, however, a danger that the more progressive local authorities may set up their own audiology clinics to the detriment of a concerted effort in the whole area. The East Cumberland Hospital Management Committee is aware of the inadequate E.N.T. out-patient facilities and the disgraceful working conditions of the audiology technicians; but financial priorities and other considerations seem to prevent immediate improvements. Similarly both the West Cumberland and Dumfries Management Committees have yet to provide suitable accommodation.

Otitis Media

" Medical interest has always inclined to the rare and spectacular and for this reason otitis, tonsillitis and the common cold are accepted as a part of childhood life, although the sequelae of these diseases may have very considerable immediate and remote effects on human well-being. These diseases are usually treated by the family doctor. The school medical officer (unless he is also a general practitioner) may not have more than an occasional experience of the acute ear.

" Recently it has been apparent that most acute attacks of otitis are but a part of a generally silent and chronic process which started in infancy. This process is a failure of the eustachian tube to evacuate the middle ear, with result that there is retention of mucus and episodes of negative pressure with retraction and stretching of the drum. Furthermore, though the mechanism is not fully understood, this process is associated with an increasing activity of the skin on the outside of the drum and adjacent meatal walls, resulting in the collection of the products of excessive desquammation in the deep meatus.

" Only the infant welfare and school medical officers can help us solve this problem since they alone have access to so many ' normal ' cases. Careful and expert clinical examination with a really good auroscope and hearing tests if possible, repeated every year of a large series might help us to decide, firstly, what is the appearance of a child's normal drum and what are the minor deviations from normal and, secondly, whether this disease (catarrhal otitis, negative pressure, glue ear—call it what you like) is self limiting or curable.

Tonsils and Adenoids

"The wordy battle between the tonsillectomists and the anti-tonsillectomists continues. Faith and emotion have surpassed science and reason. Both sides produce statistics which prove their case and probably neither understands the function of the tonsils. There are at least two facts: one that about one-fifth of all children still have the operation despite the supposed good health of modern times, and the other that it is not possible to detect microscopically whether the tonsils are harming the child or likely to do so. The public health service has at its disposal large numbers of normal children; why not take a series of photographs (which is quite easy) of a selected number of children's throats, summer and winter over a period of years in an attempt to relate the macroscopical changes with the history? We might then discover what is a normal tonsil clinically."

Provision of Hearing Aids

The total number of pupils in the schools who are known to have been provided with hearing aids is forty-five, of whom thirteen have been equipped during 1963.

Audiology Services

Although disappointed in the failure during 1963 to secure the services of a teacher of the deaf for East Cumberland, the comprehensive testing of all school entrant children has gone ahead in both East and West Cumberland, with the necessary follow-up of doubtful or suspicious cases. Dr. Timperley has taken a special interest in this work in the east of the County and gives an account below of its progress. Dr. Hunter, who has been associated closely with the audiology services in the west of the County, continues the story from that end and reviews the work over the past five years. It will be apparent that the question of possibly narrowing audiometry to children known to be "At Risk" is a live one whose answer should become clearer in the next few years.

For East Cumberland Dr. Timperley writes:—

"The position in East Cumberland, whilst following a similar scheme to the West, is approximately five years behind. Routine audiology testing of entrants only began in November, 1962, since when the following numbers have been tested.

Born:—

1957/58	1,745
1956	120
1955	103
1954	89
1953	69
1952	17
1951	2
	2,145

" Of these, 124, i.e., 6%, were found to have some degree of impaired hearing, a figure which is considerably less than that obtained in the West. Twenty-five children of moderate to severe hearing loss were referred to the school medical officer and twenty-four to the E.N.T. specialist, the remainder being checked the following term, when forty were found to have normal hearing. In addition 400 children were specially referred from the following sources:—

Teachers	300
General practitioners	3
School medical officers at routine inspection	60
Speech therapists	22
2 H.P. examinations	15
	400

Of these, forty-three, i.e., 10%, had defective hearing or were investigated further, whilst five were found to be normal after re-test. Final assessment so far has only been possible on the following:—

Severe bilateral middle ear deafness ...	1
Mild bilateral middle ear deafness ...	1
Unilateral severe nerve deafness ...	1
Mild bilateral nerve deafness ...	1
Recurrent wax	1

" There were thirty-two children in normal schools wearing hearing aids. Three children are at special schools for the deaf (one at Manchester, two at Liverpool)."

Dr Hunter's contribution from West Cumberland follows, along with an account by Mr. Abbott, peripatetic teacher of the deaf, of his work:—

"The detection of deafness from an early age has come to be an integral part of the Child Welfare and School Health Services in the area. Practically all health visitors have been trained in applying simple tests of hearing in the home and clinic to young children, along the lines taught by the Department of Audiology of the University of Manchester. A full-time audiometrician carries out routine sweep testing in school entrants and one health visitor/school nurse is also qualified to do a certain proportion of the routine work and act as a standby in time of need. Three medical officers have attended courses on the ascertainment of deafness at the University of Manchester and/or at the Audiology Unit of the Royal National Throat, Nose and Ear Hospital, London.

"The application of developmental testing of infants by the Ruth Griffiths' method has brought to light in a few cases the need for further investigation into the question of hearing. One peripatetic teacher of the deaf takes under his care the profoundly or severely deaf children for teaching and the guidance of parents in the home or in the clinics. He also supervises and checks on children with hearing aids or requiring them. Beyond these local authority workers in the field there is ready access to the otologist to whom all cases of severe deafness are referred with the agreement of the family doctor.

"The total state of deafness in children in West Cumberland has become clearer as the work has progressed over the last five years and, with a review of cases, either ascertained by sweep testing over the last six years, or discovered otherwise through school health work generally, it is possible to present a fairly accurate picture of the incidence prevailing. The investigations done have also emphasised the fact that a defect in hearing is not only an impairment of one of the senses but, where severe, is also a serious disturbance in communication and social contact. Further elucidation of deafness in the very young, and in the toddler is, perhaps, the most difficult of all tasks in the whole duty of ascertainment — the detection of the defect, the complete diagnosis and the recommendation as to special educational treatment.

"During the year 1963, a total of 2,889 first sweep tests were carried out in school entrants (1,189 in children born in 1958, 1,492 in the year group 1957 and 208 in the year group 1956). The number found to have a hearing loss was 323 (approximately 11%). Of these latter, thirty-seven cases of moderate or severe loss were referred in the first instance to the school medical officer and the balance marked down for a re-test by the audiometrician in the following term.

"All children with other handicapping conditions were also tested by the audiometrician. An entry in Forms 2 H.P. and 4 H.P. of the state of hearing is made as part of the physical examination. Some 200 children were also brought forward as special cases by the school medical officers as a result of school medical inspection, by parents and teachers and, in a few cases, by the paediatrician and otologist. In addition a review was made of most of the cases discovered since the screening tests were first introduced in 1959. This formidable task, although not quite completed at the end of 1963, is thought to have resulted in the truest picture of the incidence of loss of hearing so far obtained.

"In what follows, the terms 'mild,' 'moderate' and 'severe' relate to audiometric grading in decibel loss, i.e., mild loss is a loss up to thirty decibels average in the three frequencies 500, 1,000 and 2,000; moderate loss between thirty and fifty decibels in the same frequencies; and severe loss, above fifty decibels. Severe loss covers also profound loss in cases who have no naturally acquired speech, and those who are of partial hearing and use hearing aids.

ROUTINE SCHOOL ENTRANT GROUP

"In the 323 children of the routine school entrant group, assessment of defect of hearing had reached the following stages at the end of the year.

		Unilateral	Bilateral	Total
Under observation		—	—	191
No defect after observation ...		22	24	46
Mild:	Unilateral ...	28	—	28
	Bilateral ...	—	33	33
Moderate:	Unilateral ...	8	—	8
	Bilateral ...	—	12	12
Severe:	Unilateral ...	4	—	4
	Bilateral ...	—	1	1
		62	70	323

" All 191 cases under observation were mild in degree of loss and contained many who had temporary losses due to catarrhal colds which were prevalent in large infant departments towards the end of the year. It was this prevalence of catarrh that contributed mainly to the increase in percentage loss in 1963 (11% as compared to 5.2% in 1962). Forty-six cases with loss had reverted to normal on second testing.

" The single severe bilateral case was referred to the otologist who found a conductive cause and advised removal of adenoids and antral lavage. The four unilateral cases were all conductive losses, three being probably static after infection but one was referred to the otologist for further elucidation.

" Of the twelve bilateral cases of moderate degree, two cases were perceptive (one with a high frequency loss with no presenting factors and requiring observation, and one following an injury to the head, the defect being under observation in a Newcastle hospital). Ten moderate bilateral cases were conductive in type, two being due to wax and the remaining eight due to middle ear infection, past or present: three were referred to the otologist.

" Of the eight unilateral cases of moderate degree, one was associated with hare-lip but the type of deafness still requires elucidation; seven were conductive in type with no outstanding features.

Special Cases Referred

" Of the 200 children mentioned above who were brought forward as special cases, forty required more intensive investigation. Sixteen of the forty were referred as a result of routine or selective school medical inspections, fifteen from parents or teachers, six from the audiometrician, three from the otologists and one from the paediatrician. The distribution of these cases was as follows:—

		Unilateral	Bilateral
Mild:	Unilateral	10	—
	Bilateral	—	9
Moderate:	Unilateral	2	—
	Bilateral	—	11
Severe:	Unilateral	4	—
	Bilateral	—	4

" Of the four severe bilateral cases, one is likely to be a perceptive deafness in an emotionally upset child who is also educationally subnormal and whom the otologist has had difficulty in approaching. The paediatrician referred the second case of a brain damaged child who may benefit from a hearing aid. The third case was brought to notice by the audiometrician and is considered by the otologist to have a perceptive deafness, perhaps due to the virus of measles. The fourth case is the only conductive type of loss due to old middle ear trouble, including mastoiditis, in which a favourable position in the class at present covers the position.

" In the eleven special cases of bilateral moderate degree, two are cases of high frequency familial deafness. The mother of the family has a degree of deafness and the daughter, aged 12 years, was brought forward with a speech defect and found to have a moderate to severe loss of hearing in the frequencies in and above 1,000. She is likely to be fitted with a hearing aid in 1964. A brother, aged 8 years, has also a high frequency loss from 2,000 to 6,000 but speech is normal. He will be tested regularly. A still younger brother of 5 years has no apparent loss at present. In the conductive type, one case fitted with a hearing aid earlier in the year, after removal of adenoids and the use of the aid, had so improved as to be able to dispense with it. Two cases due to adenoids were referred to the otologist, one having been seen by the end of the year and to have adenoids removed. Four cases were seen by the otologist and recommended surgical treatment in two and medical in the third and observation in the fourth. One case with no special presenting sign except catarrh was fitted with a hearing aid and a similar case has been referred to the school medical officer. The eleventh case in this group is still under investigation and requires a differential diagnosis between conductive and perceptive deafness. She may prove to be an early case of otosclerosis. An older brother is so afflicted.

" In the two unilateral moderate cases, one is due to old mastoiditis and one to otorrhoea: the former has a favourable position in class.

" As stated above, a firm attempt was made to review all known cases of deafness among school children. To this end over 400 audiometric tests were carried out in addition to routine sweep testing and special work. Fifty children were

referred to school medical officers and twenty-four to the otologist as part of the review.

" The review was also widened to cover children right up to school leaving age for whom records of deafness had not come as a result of sweep testing since 1958, and the final figures of total state of deafness also includes children who are in special schools (sixteen in number) because of a profound loss of hearing.

Total State of Deafness in West Cumberland :
(School population approximately 25,000).

	Severe	Moderate	Mild
Unilateral ...	48	47	123
Bilateral ...	34	69	129

" The method adopted five years ago for the detection of deafness in pre-school and school children was simple screening in infants in the home and clinic and the pure tone sweep testing of school entrants. This is the most comprehensive of methods but is thought by some to be a very big net to catch small fry. The alternative system is to test only children ' At Risk,' that is, those children who have been subjected to certain adverse factors in the pre-natal, perinatal and post-natal periods of life. This system applied to a community in which an ' At Risk ' register is fully maintained should reveal nearly all cases of perceptive deafness. In this area the ideal situation for keeping a comprehensive ' At Risk ' register is still developing and, although the majority of cases of significant deafness requiring special educational treatment have been in ' At Risk ' children and have been detected in infancy, yet a number of perceptive cases with no known etiological factors have been discovered by routine audiometry at school. In addition, very many more cases have been discovered of bilateral and unilateral cases of conductive deafness in which either medical treatment, surgical interference or simple aid in hearing were needed. It is surprising how tolerant many parents are to increasing deafness or discharging ears in their offspring. There does not, therefore, seem to be a clear indication at present to change the system of detection of deafness in this area.

" The deadline of interest in cases of significant deafness hitherto set at school leaving age has been overcome by a better approach to the welfare of these handicapped youths. Regular bi-annual meetings of Youth Employment Officers, the

Secretary of the Association for the Deaf, the Area Medical Officer and the Teacher of the Deaf, were begun during the year to consider the best method of helping the individual case towards useful work. It was also arranged that the supervision of hearing aid cases by the teacher of the deaf would be extended for two years beyond school leaving age."

Mr. Abbott, the Teacher of the Deaf in West Cumberland, gives below a summary of the position from his point of view.

PRE-SCHOOL CHILDREN

" During the last twelve months, three new cases came under my care. Child (*a*) came to my attention early in the year as a little boy of twelve months. He appears to be sub-totally deaf and as yet has given no response to any auditory stimulation whatsoever. He does not get any benefit from the speech trainer or his Medresco hearing aid, even with a binaural fitting. Child (*b*) is a boy of 18 months who is severely deaf and is getting much benefit from a binaural fitting on his hearing aid. The third child (*c*), who is two years old, has been recently fitted with a hearing aid and would appear to have a lot of useful hearing.

" Three children who are related and have various hearing losses of a familial nature acquired at possibly 1-2 years of age, have recently left the area to reside near a deaf school so that they may attend as day pupils.

" One boy who is severely deaf was admitted to the Northern Counties' School for the Deaf at Newcastle-upon-Tyne. A partially hearing child with an additional handicap was admitted to a County Training Centre.

" Parent guidance and pre-school training has been carried out for all the pre-school children at County Clinics and in their homes.

" With these children, the work is essentially guidance, demonstrations being given to enable the parents to promote the development of speech and the wish to talk; encouraging the children in the use of an aid; and last, but not least, the necessity of lip reading, particularly with the more severely handicapped of this group.

" It is interesting to study the amount of time and effort devoted by the various parents concerned. For instance, one

child comes from highly intelligent parents but it is obvious that the bare minimum of help is given to this child. To substantiate this, in recent months the child has been found on several occasions to be wearing an aid which was not functioning or had the ear mould occluded by quite hard wax. It appears that in this case the parents would like everything possible done for this child but are not prepared to do very much themselves. However, there are other parents of a similar background who are manifestly doing all they can to help their child.

" Two families of less intelligent parents are also compared. The first child, although very late with his milestones, is helped in every way possible by his mother. The second child is somewhat neglected in parental help and training is made difficult by the number of people in the home, approaching double figures, and possibly more relevantly because there are two younger children demanding attention. However, this second child, who is profoundly deaf, has acquired a fair vocabulary, understands considerably more of what is said to her and, I feel sure, with eventual entry to a residential deaf school, her progress will be quite good.

Pre-school group:

Profoundly deaf	3
Severely deaf	1
Partially hearing	1
	5

Pupils in Special Schools

" The number of children from this area in residential special schools outside the county is now sixteen.

" Two children have been admitted in the last twelve months, one a profoundly deaf boy to the Northern Counties School for the Deaf, Newcastle, and the second, a girl of six years, to the Liverpool School for the Partially Deaf at Southport. This second child, although progressing in a normal school, was not deriving full benefit from the education offered to her. By comparison another girl of her age and with an almost identical hearing loss has integrated extremely well into another normal school. It was arranged to see all the above children in the first week of the summer holidays.

Children with Impaired Hearing in Normal Schools

"Currently thirty-three children with impaired hearing are under supervision in this area. Twenty-eight of these have Medresco hearing aids of mon-aural air conduction pattern and one girl has a commercial bone conduction model plus a recently introduced Medresco model for bone conduction use.

Hearing Aids

"Five new hearing aids have been issued to school children during the last year and one boy has come to this area from Carlisle city with an aid. Four children left school during the year and of these three have found jobs so far. Out of the twenty-nine children with aids, five of these are not wearing them currently because their hearing losses, which are checked regularly, have dropped to insignificant levels. All of the above aids are of the mon-aural pattern as it is felt that the binaural lead and extra receiver is of use only to the severely deaf who would require special schooling in any case.

"The following table shows the average loss for the main speech frequencies on the better ears:—

Up to 30 db.	13
30 to 40 db.	10
40 to 50 db.	9
50 to 60 db.	1
Over 60 db.	Nil
	33

"These hearing losses fall into three main categories depending on the child's history. (1) Conductive or middle ear deafness gives a 'flattish' loss over the various frequencies. (2) Familial nerve deafness gives a moderate loss on the lower frequencies with a drop on the higher frequencies. (3) Acquired nerve or inner ear deafness gives again a moderate loss in the lower frequencies with a greater loss on the higher frequencies than the inherited deafness.

"The work with these school children falls into three main categories:—

1. Supervision which includes use of hearing aid, classroom seating for hearing and lip reading, testing of loss, speech, etc.

2. Remedial work for language and reading difficulties.
3. More specialist work, such as speech correction, auditory training and lip reading exercises."

Defective Vision and Eye Conditions

Routine testing of school children's vision is now being undertaken at each " routine " medical inspection; in addition for each child reaching eight years of age; and considerable progress has been made in the southern area towards an annual vision test for all children.

Of the 3,230 school entrants examined, 172 (136) were referred for treatment, and 461 (375) for further observation. In the eight year old group 2,918 were tested and of these 167 (183) were referred for treatment and a further 355 (337) for observation. The figures shown in brackets are the corresponding figures for 1962.

The treatment and follow-up of the visual defects found at these examinations and referred to an ophthalmologist is carried out at eye clinics conducted at Carlisle, Cockermouth, Keswick, Millom, Whitehaven and Workington by Dr. A. Ross Wear, Dr. A. C. Reid, Dr. A. G. Evans and Dr. T. P. Griffith. I am very fortunate to have the comments of some of these specialists to include in this report. Dr. Reid writes as follows from West Cumberland, stressing the importance of the early detection of defects:—

" First, the eye clinics are well and regularly attended, and we get good co-operation in the majority of cases between the parents and ourselves. Down here I have noticed lately that we have been getting our cases in early, even as soon as when they join school at the age of five. This is a very good thing, because in my opinion a refractive error discovered and corrected at this time may help the intellectual advancement of the child; a child who cannot see well definitely cannot learn as quickly as a child with normal vision.

" A little more attention to orthoptic treatment in West Cumberland would be a great benefit. Orthoptic patients should be treated and seen frequently by the orthoptist. It is not much use seeing a patient once and then not seeing him again for another two months. There is, of course, difficulty in the children going to Carlisle for treatment. Also, I think some more orthoptic apparatus might be beneficial.

" I am sure that the early recognition of squints and congenital abnormalities is of great benefit to the children."

The same points about early diagnosis are emphasised by Dr. Ross Wear in an interesting commentary on the problem of amblyopia.

" The main importance of the school eye service is in detecting amblyopic or ' lazy ' eyes and then treating these as early as possible. Generally these children see adequately with one eye and never notice that the other one is defective until someone tests their vision. If this amblyopia is detected early enough, the weak eye can be made to work again by the wearing of spectacles, occlusion of the good eye, or orthoptic exercises; after the age of six this becomes progressively more difficult and an amblyopic eye first detected at the age of nine or ten years is unlikely to improve with treatment. The most valuable school eye examinations, therefore, are the ones made before the age of six, and if all school children are efficiently screened then the subsequent tests are not so important. These subsequent tests will reveal refractive errors which have developed as the child is growing and will enable spectacles to be supplied to enable the child to see more efficiently, but they are of much less value than the first examinations.

" The amblyopic eyes require a great deal of treatment and have to be seen at frequent intervals, perhaps monthly for long periods. It is here that an orthoptist is of great value to supervise the occlusion, convince the parents of the importance of continuing with this and encourage the development of normal binocular vision by various exercises. One of the best exercises for a ' lazy ' eye is to insist that an avid television viewer always watches the television picture with his or her good eye occluded; the more interested they are in the programme the more successful the treatment.

" Apart from the provision of spectacles and the treatment of eye defects, I find that an important function of the school eye service is the explanation to the parents of what is wrong, if anything, with their children's eyes and what their visual standard is likely to be as they grow up. This may be of great importance if they have already decided to be engine drivers or naval officers.

" One is always reluctant to inflict the wearing of spectacles on a child unless it is absolutely necessary, and often with

small refractive errors their vision may be slightly below the average but they have no symptoms. Such children are told, usually to their great delight, that spectacles are not necessary but that they should have their eyes examined at regular intervals in case things get worse.

" I believe that the school eye service continues to perform a very useful function in the National Health Service and that it is better for school children to be examined in separate clinics such as these rather than in hospital out-patient clinics."

Reviewing his first eighteen months in Cumberland Dr. Griffith gives a very thoughtful assessment of the situation with some new suggestions which should be discussed further:—

" Viewed over all during my first eighteen months of close participation in the school eye clinics in West Cumberland, they would seem to be providing a very satisfactory method of surveillance, the refraction and squint cases providing as they do a limited range of types of case in a particular age group, and so avoiding the mixing of adult and child cases which can be tiring to both parties. One main reason for this being so satisfactory would seem to be that the appointments and records are carried out by the local authority. In particular, the running of the actual clinics by the school nurse is most successful, since they are often in a position to provide invaluable on the spot information which would be impossible to obtain in any other way. In particular they know what is happening in the schools in question, they know many of the teachers, and they can also follow up non-attenders, so that treatment is carried out; and also provide guidance as to any particular family problems.

" At the moment, with Whitehaven Hospital clinic facilities being limited, the clinics are held at Flatt Walks, but I hope that with the opening of the West Cumberland Hospital all my school clinics will be held on hospital premises. I think this is desirable, since besides being, as I understand, a Ministry aim, it saves the needless duplication of equipment, especially as regards orthoptic equipment. I regard orthoptics as a most important aid to the proper management of squint cases and as the means of getting successful results in many marginal cases which would have otherwise been failures. I feel there is ample work for a full-time orthoptist in West Cumberland alone, since I anticipate that at least six sessions would be used in

conjunction with hospital clinics, leaving five sessions at the most which should easily be occupied by school clinics, possibly two for the Whitehaven area, two for the Workington area and one for Cockermouth.

" In view of the place of work being hospital, and the majority of time being occupied by hospital clinics, I would suggest the orthoptist should be a hospital appointment with remuneration by the local authority for school clinic sessions. I would hope that the attractions of a new department, in a new hospital, with good equipment, would enable us to be successful in obtaining a suitable applicant. Discussion of cases and problems is often most stimulating, and possibly the post would be even more attractive if one could offer a joint session, weekly or fortnightly, with the East Cumberland orthoptist.

" With regard to vision testing, I regard the initial eye test as the most important, since if squints and poor visual acuity are picked up at this age successful treatment is often possible. The value of this vision testing decreases with each year, as the chances of successful treatment decrease with increasing age.

" If there are ample staff to do the proposed annual vision testing, in addition to the usual approximately eight and ten year old tests, I would agree that it is desirable and would pick up the odd extra case, but would think that there are possibly more useful investigations to be done. My reason for this opinion is that I imagine the various types of case that it would be hoped to find by the annual test would be (1) New squints with or without a fall in visual acuity. (2) Myopia. (3) Eye disease. However, I think relatively few squints develop after the age of five, and if they do so it is most unlikely that they would be unnoticed. Also, good vision having been obtained once, any loss due to squint occurring should be rapidly regained. The development of myopia will not lead to any amblyopia, and if it is to such an extent that visual difficulty is caused this will, in the vast majority of cases, be commented on by the patients or their families, or noticed by the teachers. The incidence of eye disease that would not draw attention to itself on account of pain or inflammation is, I would think, too low to warrant the expenditure of much time.

" Preventive medicine is obviously a most desirable aim, and I would think that if there is ample staff a yearly check of all aspects of child health would be desirable, but would think that the setting up of Local Authority Glaucoma Clinics would produce many more useful results with the limited staff available."

Ascertainment and Treatment of Squint

As I would have expected the consultant ophthalmologists have stressed the value of a regular and adequate orthoptic service. This it has not, unhappily, been possible to provide in 1963. All that has been possible is the continuance of a minimal amount of sessional work by a part-time orthoptist in Carlisle. A small number of high priority cases have come up for assessment or treatment from West Cumberland but the main volume of orthoptic work is not able to receive the attention by an orthoptist which it merits. It is highly regrettable that this important service is so defective throughout the country owing to a serious shortage of trained staff. At the time of writing, however, I am glad to say that the sessional help being given by Mrs. Richardson is being increased somewhat and the suggestions advanced by Dr. Griffith with regard to the possible attraction of a suitable person to the West Cumberland Hospital is being actively followed up.

Orthopaedic and Postural Conditions

The school children continue to be well served by Mr. McKechnie, Mr. Gordon and Miss Bucknell, consultant orthopaedic surgeons, seconded by the Regional Hospital Board for work in County Council clinics. Their work in partnership with the two County Council orthopaedic physiotherapists is reflected in the following table:—

Number on aftercare register at 1.1.63 ...	1,132
New cases during 1963	115
Cases referred for orthopaedic physiotherapist only	108
Cases re-notified after previous discharge ...	5
Cases attaining school age after having been referred originally from child welfare clinic	98
Number removed from register	284
Number on register at 31.12.63	1,174
Attendances at surgeons' clinics	619

Attendances at intermediate clinics	2,431
Homes visited by orthopaedic physiotherapists	421
Plasters applied	47
Surgical boots and appliances supplied and renewed (including insoles)...	424
X-ray examinations during 1963	50

Conditions affecting School Children:

Flat feet	390
Bow legs and knock knees	288
Poliomyelitis	36
Scoliosis, lordosis and kyphosis	17
Congenital defects (including talipes and pes cavus)	114
Congenital dislocation of the hip	23
Torticollis	6
Injuries (including fractures)	7
Cerebral palsy	71
Postural defects	62
Hallux valgus and deformed toes	39
Disc	1
Birth injuries (Erbs)	5
Osteomyelitis	2
Perthes disease and coxa vara...	16
Arthritis	—
Spina Bifida	5
Synovitis and rheumatism	3
Schlatter's disease	1
Muscular dystrophy	3
T.B. joints	4
Paraplegia	2
Other conditions	79
	1,174

Miss Morris, orthopaedic physiotherapist, again contributes an interesting note on her work.

" Last year I wrote about our difficulties in assisting in the treatment of the minor foot defects when the standard and type of shoe worn by the school children, particularly those over eleven, are so unsuitable. There has been little change here and

until the fashion changes for slip on and casual shoes for girls, and more and more pointed toes for boys as well, apparently not very much can be done about it.

" Apart from this, the types of postural defects referred from school medical inspections to our clinics are, on the whole, less severe than they used to be. It is rare for a case of severe knock knee, bow legs or deformed feet to be noticed for the first time after they have commenced school.

" Posture in the growing school child is, I feel, a very important point to be observed and referred to the clinic; either the early mild type of relaxed posture, or in the teenager, the round back and shoulders, which are fast becoming a fixed deformity. I really should like to see less severe postural defects treated in classes once or twice a week in the larger secondary schools, either by an orthopaedic physiotherapist or a remedial gymnast moving around the schools of the county. I feel this would help to create an even greater awareness in the schools of the importance of good poise both sitting, standing and walking, and carry further the excellent work of physical education instructors for the most needy cases.

" There is still quite a number of severely handicapped school children attending our clinics for splint supervision and review—mostly suffering from the after effects of poliomyelitis, surgical T.B. or some congenital deformity. It is interesting to note how well these children, in almost every case, accommodate to the school routine and are accepted and helped without any fuss by their school mates."

Speech Therapy

This year the speech therapy service has been seriously disrupted by Miss Moon's continued absence after her car accident, and by Miss Allan's resignation in April. There have been no speech therapy clinics in South Cumberland since April, 1963, and only one weekly clinic for treatment in Workington for the whole of 1963. Obviously there are long waiting lists in these areas. We were fortunate in having the continued part-time service of Mrs. Latimer in Carlisle. Mrs. Aitchison reopened the clinic in Cockermouth for one day a week in the latter part of the year. Because of this acute staff shortage most of the time has been spent in school clinics, although some treatment has been given in schools where circumstances make it impossible for the children to get to a

clinic. The review clinic for post-operative cases of cleft palate takes place in the Cumberland Infirmary and is attended by the county speech therapist. The majority of patients seen are county children and, where necessary, speech therapy is given in the local clinic.

Mrs. Blacklock writes:—

" Speech therapy is essentially concerned with individuals within their particular environment. Each child has to be assessed thoroughly in terms of levels of physical and emotional development and a complete appraisal made of his speech and language. Then a plan of treatment is organised, based upon certain principles and adapted continually as the treatment sessions proceed. The decision to take a child on for regular treatment frequently depends on the effect that the speech defect is having on either the child or his parents rather than on the severity of the defect. It is obvious that more often parents are very worried by the most severe defects and so the child becomes emotionally disturbed. This was the case with a four year old boy who had defective articulation and a stammer. The parents were very critical of the boy's speech. He was corrected frequently and, consequently, became very resistant about this. He had older sisters who were not prepared to let him follow the natural stages of development; he was expected to draw and manipulate toys at their level rather than his own. Consequently he was always failing. He was very resistant and aggressive in the play sessions at the clinic, so ample opportunity was afforded him to express his feelings and master the play material so that he earned the praise given. Gradually the relationship between him and his family improved, the stammer became much less evident and his articulation by the time he was six years old was average for his age and only the ' s ' sound was not yet used in general conversation. He did well at school and the teacher was very pleased with his progress.

" In contrast parents are often very worried by a very simple defect. A little girl was referred at 3½ years of age because her articulation was not normal though, in fact, it came well within the average speech development level. Advice was given to the mother and the child kept under review. Three months before she started school weekly treatment was begun. She was a pretty child who was over-protected and very inclined to be babyish and exhibitionist in behaviour. Some progress

was made. She started school and speech therapy was discontinued so that the child would have a better chance to settle. After three months she was seen again. The mother was obviously happier about the child and said, ' to think I worried —how much she has improved.' In fact the articulation was altered little but the child was doing very well at school and the mother was now obviously convinced that the delayed speech development was not associated with delayed mental ability.

" With defects of articulation the aim of speech therapy obviously is normal speech and, in the majority of cases, this aim is achieved. However, with stammering the symptom is more often very closely associated with emotional disturbance and the treatment aims at a normal emotional adjustment to the stammer. When a person stammers the least notice taken of it by others is the best, but frequently parents, teachers and neighbours tell a child to start again, take a deep breath, and various other ' aids.' The child becomes very self-conscious of this speech that calls forth so much adverse criticism from those he wishes to speak to that he does anything to avoid stammering. That is where the harm lies — he swops words, speaks as little as possible, avoids talking situations like shopping and telephoning and other social activities. One fourteen year old grammar school boy was referred with a moderately severe stammer. He did go to a dancing class and play an instrument in the local band but was very self-conscious about his speech. He admitted changing words in a sentence and avoiding difficult words. He never looked at the person to whom he was talking. He would not telephone or shop and always had the exact fare when travelling on a bus. Treatment included relaxation and general discussion with emphasis on the stammer itself and his attitude to it. By the time he was studying for his advanced level G.C.E. he was able to report that he rarely thought about his stammer. He has made a very good adjustment and, although the stammer is still noticeable, it does not bother him.

" In Maryport this year a mixed group of children between the ages of 9-11 years old with either a stammer or dyspraxia have frequently been telephoning Miss Moon. The experiment started by their being persuaded to have a word with her, gradually the children who had never previously spoken on the telephone requested that this be part of the

weekly treatment. It has been most interesting to see their telephone technique and conversation develop. They can all now ask for the service, the number, to be informed of the price and engage in conversation with Miss Moon. One girl with a severe stammer quite independently phones each week from a call box—reversing the charges!"

The following table shows details of cases treated and attendances during the year:—

	North Cumberland	West Cumberland	South Cumberland	Total
On register 1.1.63	137	130	167	434
Admitted	8	139	53	200
Discharged	6	109	22	137
On register 31.12.63... ...	139	160	198	497
Waiting list (included on line above)	—	129	102	231
Particulars of cases discharged:—				
Normal	4	63	17	84
Improved, unlikely to benefit further	1	21	3	25
Lack of co-operation ...	—	22	1	23
Left school and/or district ...	1	3	1	5
Passed to teacher of deaf ...	—	—	—	—
	6	109	22	137
Cases treated:—				
Dyslalia	11	96	19	126
Stammer	7	58	41	106
Stammer and dyslalia ...	9	35	3	47
Sigmatism	2	—	5	7
Cleft palate	4	19	10	33
Hard of hearing	1	4	—	5
Dysarthia	1	3	1	5
Dysphonia	—	—	—	—
Dysphasia	—	—	1	1
Retarded speech development	15	48	43	106
Dyslalia and dysphonia ...	1	—	—	1
Dyslalia plus low intelligence	1	—	—	1
Lateral sigmatism	4	7	4	15
Dyspraxia	1	11	3	15
Submucous cleft	—	1	1	2
Hyponasality	—	1	2	3
	57	283	133	473

Attendances:—

	Attendances	Waiting List
Cleator Moor	49	6
Egremont	41	6
Ingwell	47	—
Millom area	115	18
Seascale	16	1
Whitehaven	159	71
Cockermouth	26	7
Keswick	28	1
Penrith	61	—
Workington	273	114
Aspatria	130	—
Carlisle	508	4
Maryport	282	3
Wigton	203	—
Wiggonby School	50	—
Plumbland School	88	—
	2,076	231

Child Guidance

Child guidance clinics continued to be held regularly both in East Cumberland at Carlisle, where Dr. Stuart is director of the clinic, and in West Cumberland at Maryport, Workington, Whitehaven and Millom, under the directorship of Dr. Ferguson. In West Cumberland, in addition, Dr. Drummond has followed up the hospital child psychiatry out-patient clinics which Dr. Gibson commenced and I quote below some of his comments on his experiences of this so far.

In East Cumberland the team of psychiatrist, educational psychologist and psychiatric social worker has continued to work smoothly and effectively. Fortunately Miss Welch returned from her training course about the same time as Mr. Mayoh resigned as psychiatric social worker so that there was little loss of continuity there.

In West Cumberland the arrangement reported last year whereby selected school nurses filled the rôle of the psychiatric social worker as fully as possible has continued at Dr. Ferguson's clinics. It is to be hoped, however, that as early as possible in 1964 it will be possible to appoint a further psychiatric social

worker in West Cumberland who will, in fact, become the senior social worker in either the western or southern area of the county. A part-time psychiatric social worker is employed by the hospital management committee in connection with Dr. Drummond's child psychiatry out-patients' clinic. Mr. Hare, Educational Psychologist, has kindly contributed the following on the work of the West Cumberland Child Guidance clinics:—

"This year has been one of satisfactory progress and consolidation. Attendances and referrals have maintained their previous levels. We have on average had two to three new cases referred to us on each clinic session. The nature and method of many of these new referrals reflects a growing confidence in the service we have to offer, among referring agencies. Our relationship with local medical practitioners, heads of schools, probation and child care officers, has been strengthened. This is a very welcome tendency.

"In many ways child guidance work, though organised on a tripartite disciplinary basis, involves all those aspects of applied social science relevant to the child and his environment. No child guidance team can function adequately in isolation without inter-acting with other workers.

"A highly successful seminar on adoption was held with the local branch of the Royal College of Midwives at Whitehaven. This meeting had wider repercussions and our advice on this sensitive matter has been sought by other workers. It is interesting that we have recently seen an adopted child whose adopted sister we also saw a year ago. This encounter with the obverse of a relationship we previously explored produced many interesting facets. We found, for example, an identical intelligence quotient with perfect identity in inter sub test variability. Psychometrically this is quite unique.

"This year has also seen a new emphasis on the prevention of juvenile delinquency. Already we give considerable help to the Probation Service, both before and after Court appearances. This is always done where a child offender is already known to us and, perhaps, currently being seen by us. In other cases our help may be requested where a child presents some baffling features of behaviour.

"Recently we were asked to see again a boy accused of stealing. We had previously seen him some months ago when,

with supportive interviews, we felt we were helping him to make a better adjustment.

" This boy's demeanour at times has been one of extreme composure and placidity, with very little sign of concern and certainly none of remorse. His background is a relatively good one and he is a boy of bright intelligence. We were able to explore his personality and phantasy with objective psychological techniques, which provided us with many clues towards explaining his behaviour."

In connection with his hospital clinic activities, Dr. Drummond comments as follows:—

" During the seven months from 1st August, 1963, to 29th February, 1964, I saw six new cases in the child psychiatric clinic. I have little doubt that this represents only a fraction of the children who could benefit from a properly staffed psychiatric service.

" We have an excellent educational psychologist in the person of Mr. Hare and a psychiatric social worker, Mrs. Robson, who is particularly interested in children's work.

" I feel there is a genuine need for a properly trained child psychiatrist in the county as a whole, although I do not think there would be sufficient work for him or her in West Cumberland alone."

The need Dr. Drummond refers to for a specialist child psychiatrist is one which is felt in most areas. The number of these specialists is still so small; the nearest child psychiatrist whose services can be called upon is at the Child Psychiatry Unit attached to the General Hospital, Newcastle-on-Tyne. The services of this clinic at Newcastle have been most valuable for one or two children during the year who presented particularly difficult problems, but the waiting time for an appointment has been very long, apart from the geographical difficulties involved.

On 14th November Dr. Llewellin, Senior Medical Officer, Ministry of Education, visited the county in connection with an investigation of child guidance clinics throughout the county. A very frank and profitable discussion was held with all the workers in the child guidance field in the county.

CHILD GUIDANCE CENTRES—STATISTICAL RETURN FOR THE YEAR ENDED 31.12.63

STAFF:	Carlisle:	Maryport:	Whitehaven:	Millom:	
Psychiatrist	Dr. Stuart	Dr. Ferguson	Dr. Ferguson	Dr. Ferguson	Total
Educational Psychologist	Dr. H. Blair Hood	Dr. H. Blair Hood	Mr. K. G. Hare	Mr. K. G. Hare	
Psychiatric Social Worker	Mr. L. Mayoh				
Cases remaining on register at 1st January, 1963	27	15	240	19	301
New cases referred during year by:—					
Consultants or General Practitioners ...	26	6	20	—	52
School Medical Officers...	10	3	51	5	69
Children's Officers	1	—	1	—	2
Parents	—	—	2	—	2
Schools	2	5	—	—	7
Probation Officers or Courts	1	—	6	2	9
Others	1	—	—	—	1
Cases re-opened during year	6	—	—	—	6
Total cases on register during year ...	74	29	320	26	449
Cases dealt with and closed	48	14	10	—	72
Cases remaining under treatment on 31.12.63	25	15	310	26	376
Cases awaiting treatment on 31.12.63 ...	1	—	—	—	1
	74	29	320	26	449
Interviews by Psychiatrists	277	93	274	36	680
Interviews by Social Workers	43	37	*—	*—	80
Interviews by Educational Psychologists ...	44	111	264	36	455

*No social worker

HANDICAPPED PUPILS

Cumberland's peri-natal mortality rate (the number of stillbirths and deaths in the first week of life, per 1,000 live and stillbirths) was 33.0 in 1963. This compares with a rate of 35.8 in 1962 and 41.3 in 1953. The significance of these figures for the school health service in its work with handicapped children is considerable. There can be little doubt but that the survival of many children suffering physical and/or mental defects at birth will progressively add to the numbers of handicapped school children and, as has also often been said before, to many more sufferers of multiple handicaps.

All of this relates closely, as I pointed out in my report last year, to the compilation of an " At Risk " register which progressively " fades " into the Handicapped Pupils register by the age of school entry. I have referred earlier in this report to this and to the new register of congenital abnormalities apparent at birth. There were 280 names added to the " At Risk " register in 1963, an incidence of 7% of total live births. 64% of these children were placed on the register on account of prematurity. Thereafter difficulties associated with the birth were the main indications for addition to the register.

In November this year the Ministry of Health issued a memorandum to local authorities requesting that information should be sent to the Registrar General of all cases of congenital malformation which are apparent at birth (live or still). A simple form has been devised for such cases, which is completed either by the midwife or doctor in attendance at the birth, and forwarded to this office with the birth notification card. This register is at present running in parallel with the " At Risk " register.

The continuing care of the handicapped school leaver is still very much before me and below are recorded some new approaches to the deaf and partially hearing and the blind and partially sighted. Indeed, as indicated in connection with " case conferences " regarding deaf and partially hearing children, this very necessary approach will be more firmly established in each area in the course of the next year.

The results of the year's follow-up of educationally subnormal school leavers is again recounted below. All of these handicapped groups entering an increasingly complex and com-

petitive world, both in respect of employment and, to some extent also of leisure, will need all the support and help which the developing field resources of the world of "social work" can offer. Much of this will come from the health and welfare department's welfare and mental welfare officers working alongside the health visitors and under the overall guidance of the area medical officer.

The British Council for the Rehabilitation of the Disabled, published at the end of the year "The Handicapped School Leaver," the report of a working party. Many of the conclusions of this body are, undoubtedly, helpful and significant pointers to future progress in this field and I hope the main recommendations will be discussed by the Joint Sub (Health and Education) Committee. It can fairly be said, however, that much of the thought there expressed is already embodied in the measures and proposal already outlined above for Cumberland. The advantages of combination of health and welfare services again become clearly apparent here.

I was very glad of the opportunity in November to present a picture of some of the work carried out for handicapped pupils by the school health service to a teacher's informal reception arranged at Workington Grammar School by Mr. Bessey, Director of Education, for teachers coming newly into appointments in Cumberland. I am sure that this kind of opportunity is very helpful in promoting the understanding between teaching and school health service staff which is so vital, particularly in the case of handicapped pupils.

Blind and Partially Sighted Pupils

There are seven blind children and three partially sighted in special residential schools outside the county, and we continue to be fortunate in Cumberland in experiencing little difficulty in finding places for such cases in special schools. Of the eighteen ascertained partially sighted children in the county, a third child has been issued during 1963 with an illuminated desk magnifier, enabling the boy concerned to continue in ordinary school. Five of the eighteen children mentioned have other handicaps, three being degrees of deafness, a fourth a spastic condition, and a fifth hydrocephalus.

Three young people in this category of handicap left school in 1963, two leaving ordinary school and one a school for

the partially sighted. Two young boys who were withdrawn from schools for partially sighted this year have now started to attend ordinary school. One was withdrawn from special school by the parents against professional advice, and the other could not be retained in special school because of his failure to settle in various respects. Of the three children who left school one is employed as a gardener by an urban district council, another is receiving home tuition in craft work and Braille, and a third child has recently had an operation on his eyes and it is hoped that it will be possible to remove his name from the handicapped register.

In my report for 1962 I mentioned that the Royal National Institute for the Blind had issued a memorandum on the care of young blind children which discussed the value of meetings of parents of blind children. Two such meetings have, in fact, already been held in Cumberland and further such gatherings are envisaged. Because of geographical factors and the small numbers involved, it is not possible to separate the parents of young blind children from those of older children. This difficulty looks, however, as though it can be turned to advantage. The limited experience so far suggests that the parents of the younger children have a great deal to learn from those with longer experience of their problems. The latter are only too happy to be of this service and features concerning training and employment of blind children are of equal interest, in the long view, to the young child's parents as to those more immediately concerned with this problem.

Deaf and Partially Hearing Pupils

Of the thirty-six children known to be handicapped by deafness or partial hearing, twenty-one are in special schools.

Increasing attention is now being paid to the possibility of the partially hearing child being educated in ordinary school —probably a special class. Cumberland, being a scattered rural county, poses a special problem, particularly as the number of pupils in this category is comparatively small. It has been agreed, however, that a survey should be made during the current year of all children at residential schools for the deaf and partially hearing, the school medical officer in each case co-operating with the teacher of the deaf to determine which of these children could reasonably be catered for in a special day class if such were to be provided in any area of

the county. Such a class would, of course, also serve some of the partially hearing children at present in ordinary schools in the particular area of the county.

A disappointment in 1963 has been the failure to recruit a teacher of the deaf for East Cumberland. It is hoped that this vacancy will be filled in the near future, but in the meantime a specially equipped room is being made available for him or her in the Carlisle clinic.

A system of case conferences on deaf and partially hearing school leavers has now been established in West Cumberland where the Senior Assistant County Medical Officer is able to discuss the welfare of these children with the teacher of the deaf, a representative of the Carlisle Diocesan Association for the Deaf, and the youth employment officers in the area. The first meeting has already been held and all concerned expressed the view that it was a success and should be followed up—probably each leaving term. This is, indeed, likely to establish a pattern within the compass of area administration for the consideration of the needs and subsequent follow-up of all handicapped leavers. Secure and suitable employment is a primary aim, of course, while the widest aspects of welfare can be taken care of at the same time.

During the year one girl left a special residential school for the deaf on emigrating to Canada. Another girl was transferred from one residential school to another because of family movements.

Children suffering from Epilepsy

There are forty-two school children suffering from epilepsy in Cumberland, two of whom are in special residential schools. Most epileptics can be educated quite satisfactorily in ordinary schools. The two who are in special schools require this additional provision because of associated emotional instability in one case and hyperactivity in the other.

One case in ordinary school which has given considerable anxiety during the year is a boy of fourteen who has, unfortunately, been allowed access at home to the drugs which he uses to control his epilepsy, and has on more than one occasion been seriously ill as a result. Fortunately his parents have at

last consented to his being admitted to a residential school for epileptic children where his general care and discipline will be much better than that which he receives at home.

Educationally Subnormal Pupils

The numbers of 2 H.P. examinations completed in 1963 and the waiting list for Ingwell and Higham Schools are shown below. There was again this year a large number of failures to keep appointments for 2 H.P. examinations, in many cases neither warning nor explanation being given. This continues to result in wastage of the school medical officer's time and, indeed, the only solution appears to be in still further recruiting the assistance of the school attendance and welfare officers and school nurses in seeing that these appointments are kept.

The probable inclusion of proposals for the extension of Ingwell School in the Education Committee's 1965-66 building programme is encouraging in view of the now familiar and persistently long waiting list for the school. Similarly, it is to be hoped that a scheme for the extension of Higham School will meet with Ministry approval in due course.

There were thirty-four children ascertained this year as educationally subnormal (forty-nine in 1962) and recommended for education in special schools, although less than half can hope to receive this type of education. At the end of the year nineteen of the twenty-four non-selective secondary schools had recognised progress classes and about thirteen junior schools (only one recognised) had these also.

The arrangements for the supervision of educationally subnormal school leavers continue to work very satisfactorily, and of the forty-two educationally subnormal children who left school this year twenty-five (59%) were placed under supervision, sixteen by health visitors and nine by mental welfare officers, although the parents of two children in the latter group subsequently refused this supervision. The remaining seven placed under the supervision of the mental welfare officers are the more serious cases, because of their delinquent tendencies or very limited intelligence. The two children whose parents refused supervision have both found employment and two of the seven being supervised are also in regular employment and have caused no trouble. Of the

remainder two can be considered unemployable, one is in an adult training centre to which the remaining two are shortly to be admitted. The provision of adult training centre facilities in the county for the first time, meets a need, if sometimes temporary, for some of the educationally subnormal leavers in the lower range of ability. As such centres are increasingly orientated towards industrial activities, they should (working in conjunction with the youth employment officers) be able to prepare some of these young people for open industry.

The position regarding those placed under health visitor supervision this year is much brighter. Only six of these thirty children are unemployed, three of whom are looking for vacancies, two quite content to remain unemployed and one, unfortunately, has been unable to keep either of the two jobs she has had.

Of the thirty-two children placed under health visitors' supervision in the previous year twenty-five (78%) are now in regular employment, and of the seven unemployed, four are attributable to the unemployment situation and three can be classed as unemployable, viz., one child who is a severe epileptic, another under treatment for mental disorder and a third who suffers from nervous depression. The position regarding the eight children placed under Mental Welfare Officer supervision in 1962 remains much the same as one year ago. Four are in regular employment and are causing no trouble; indeed the young man who set himself up in business as a newspaper vendor still continues to do well. Of the remainder, two are unemployed—one having been dismissed on account of insolence. The other two young people are unemployable—one having now been admitted to an epileptic colony and the parents of the other child appearing not to recognise her limitations.

2 H.P. EXAMINATIONS COMPLETED IN 1963 UNDER SECTION 34 or 57

Recommended Special School—E.S.N. ...	34	
Recommended Special Class—E.S.N. ...	28	
Reported unsuitable for education at school ...	19	
No special educational treatment required ...	11	
Decision deferred	16	
Total ...	108	(129)

Number of boys on waiting list for Ingwell School	68	
Number of girls on waiting list for Higham School	44	
Total ...	112	(134)

NEW CASES REFERRED IN 1963

Placed under supervision for further investigation of intellectual capacity

Referred by:—

School Medical Officers	57	
Psychologists and Teachers	54	
Consultants and Hospitals	24	
Health Visitors	36	
Others	11	
Total ...	182	(83)

The figures shown in brackets against each total are the corresponding figures for 1962. The number of 2 H.P. examinations remains constant, although there was a considerable increase in new cases referred for further investigation of intellectual capacity. The majority of the new cases are referred by the school medical officers, teachers and psychologists, although it is interesting to note that in 1963 the number of referrals by health visitors of children under school age has increased substantially.

Physically Handicapped Pupils

Apart from the educationally subnormal school children, this is the largest group of handicapped children. A further forty-seven children were ascertained as physically handicapped during 1963, and the total number in the county is now 197.

Spastics numbering fifty-one, or 26%, and children with orthopaedic conditions numbering forty-seven, or 23%, are the largest groups of those ascertained. A growing number of the children with these defects are known before school entry and the school medical officer at an appropriate stage completes a form 4 H.P. for the child, recording details of the handicap and, if necessary, recommending special educational treatment. This treatment varies in that the recommendation may be for some limitation in physical activities, for special transport to and from school and, in certain instances, special schooling.

Of the other two main categories, thirty children have heart conditions, most of which are congenital in origin, and twenty-eight children have respiratory conditions.

During 1964/65 a start will be made on the erection of a home for the younger handicapped in Maryport, more about which I should be able to report next year. A residential unit at the Percy Hedley Centre, Newcastle, is to be opened in 1964 for cerebral palsied young people beyond the age of school leaving. In addition the National Spastics Society has plans for the early establishment of a residential centre for adult spastics at Carleton, near Carlisle.

These various provisions affecting some of this group as they advance from school age to adulthood should provide an unusually comprehensive range of residential provision in

this field of work as far as Cumberland is concerned. The unfailing help still given by Dr. Ellis from the Percy Hedley Centre, Newcastle, on advising on the problems of cerebral palsy is again gratefully acknowledged.

Children suffering from Cerebral Palsy

The numbers in this category at 31st December, 1963, are as follows:—

Number of spastic children of school age—

West Cumberland	48
East Cumberland	17
Total ...	65

These may be divided into those:—

(*a*) Attending ordinary school	39
(*b*) Attending Percy Hedley School for Spastics, Newcastle	5
(*c*) At Residential Schools for the Physically Handicapped	3
(*d*) At Residential Schools for the Educationally Subnormal	1
(*e*) Attending Training Centre	2
(*f*) At Dovenby Hospital	5
(*g*) At Prudhoe Hospital	1
(*h*) Having home tuition	3
(*i*) Not attending school, not having home tuition	6

In addition:—

Number of children under school age but within the scope of the Education Act, 1944 (i.e., 2-5 years) who are known spastics—

West Cumberland	10
East Cumberland	3
Total ...	13

Table Showing Handicapped Children in Special Schools

BLIND	Boys	Girls
Royal Victoria School for the Blind, Newcastle ...	4	1
Worcester College	1	—
Total ...	5	1

PARTIALLY SIGHTED		
Exhall Grange School, Warwickshire	1	1
Barclay School for Partially Sighted Girls, Berkshire	—	1
Total ...	1	2

DEAF		
Northern Counties School for the Deaf, Newcastle	1	1
St. John's, Boston Spa	1	2
Royal Cross School for the Deaf, Preston ...	—	3
Royal Residential Schools for the Deaf, Manchester	—	2
Bridge House School, Yorkshire	1	—
Total ...	3	8

PARTIALLY HEARING		
Liverpool School for the Partially Deaf, Southport	1	4
Northern Counties School for the Deaf, Newcastle	2	—
St. John's, Boston Spa	—	1
Royal Cross School for the Deaf, Preston ...	—	1
Total ...	3	6

EDUCATIONALLY SUBNORMAL		
Ingwell School, Moor Row	48	—
Higham School, Bassenthwaite Lake	—	34
York Day School, Carlisle...	1	1
Eden Grove School, Bolton, Appleby	1	—
Total ...	50	35

EPILEPTIC

	Boys	Girls
Colthurst House School for Epileptics, Warford, Cheshire	2	—
Total ...	2	—

DELICATE

Children's Convalescent Home, Cheshire... ...	—	1
Total ...	—	1

PHYSICALLY HANDICAPPED

Hesley Hall School for Physically Handicapped, Tickhill, Notts.	1	—
Percy Hedley School for Spastic Children, Newcastle	3	3
Irton Hall School, Holmrook	2	1
Exhall Grange School, Warwickshire	1	—
Singleton Hall School, Nr. Blackpool	1	—
Hawksworth Hall Residential School, Guiseley, Leeds	—	1
Total ...	8	5

DENTAL SERVICE

This year has seen the opening of a new clinic at Seascale, which has proved to be most beneficial to the general public and, in particular, to the school population. In the past all children from Seascale, except those attending secondary school, had to travel to Egremont Clinic and this arrangement did not work out too well in practice because parents had to accompany the younger children.

Until about fifteen years ago dental officers used to go to the schools to carry out dental treatment, using portable equipment, and often having to work in part of a classroom partitioned off with blackboards and working with inadequate light. All this is a thing of the past. The children are now treated in permanent clinics and transport is provided for those who have no reasonably easy access to a clinic by the public services. As a result, a much better and more comprehensive service is provided.

Since all the dental officers had a twelve weeks course in orthodontics there has been much better diagnosis of the irregularities of children's teeth and, consequently, suitable treatment is initiated at the correct time. There is no doubt that in future the largest proportion of a dentist's time will be spent on orthodontics and preventative dentistry. The consultant orthodontist has spent several sessions seeing patients in the more remote County Council clinics. This has proved to be of inestimable value.

One dental officer is actively engaged on research into the causes of dental decay. Work of this nature should be most strongly encouraged in local authority clinics because the material is there and, also, one should realise that the first duty of those engaged in the local authority health services should be prevention—when one knows the cause.

It is still most disturbing to see the apathy exhibited by many young people towards either oral hygiene or the treatment of dental disease. One can only hope that by suitable educational programmes these youngsters may be made to see the folly of their ways. There will always be a " hard core "

of both parents and children who could not care less about their health or appearance, but it should be one of our primary tasks to break down this resistance to receiving dental treatment before it is too late to save their teeth.

The dental service has the full co-operation of the school medical officers and one cannot stress too strongly how this is bringing about a safer and more comprehensive range of treatment for all children. Any who suffer from a disease which would make dental treatment unsafe—particularly the administration of general anaesthetics—or who are taking drugs which might be incompatible with those used by the dental officers, are notified to the Principal Dental Officer as a " dental risk " so that the child's record card can be marked accordingly. At this juncture one should make special mention of the help which the hospitals give in admitting these " risk " cases, advice as regards treatment and for X-Ray and pathological services.

More dental officers are being sent on post-graduate courses than in the past because of the great changes which are constantly occurring in dentistry and allied sciences, and also it is essential to ensure that all staff are given the opportunity of taking advantage of the many courses offered.

Due to an abnormally high sickness rate among dental officers in 1963 rather less work was done—one dental officer being absent for three months and one resigned in November to work in East Africa and was not replaced until January. Both staff and patients will regret Mr. Macdonald's departure, but it is a pleasure to have such an admirable successor in Mr. Martin Green, L.D.S.R.C.S.

PREVENTION OF INFECTION

Protection against Tuberculosis

The practise continued during the year of offering each thirteen year old a skin test (Mantoux) and, where necessary, follow-up with B.C.G. vaccination. The percentage showing a positive test, which usually indicates some previous contact with tuberculosis and subsequent immunity development, was lower (11.9%) than in 1962 (13.3%), thus following the downward " curve " of this figure since 1956. It is the majority who are negative, who are advised to have B.C.G. vaccination. The picture emerging today of the degree of immunity against tuberculosis of the older school child, relates closely to the community situation as a whole in respect of this disease.

As with all infectious diseases, however, a major conquest in the incidence of the disease leaves behind problems in maintaining a community resistance or immunity. The above figures show that each year more school children are reaching the older age groups with no immunity at all against tuberculosis. The main incidence of tuberculosis today is, however, among young adults. Vaccination in early childhood is not, therefore, generally considered a necessary or advisable measure. The effect of B.C.G. vaccination is now known to last at least seven and a half years. There is some justification, however, for slowly over the years reducing the age at which B.C.G. vaccination is given and in 1964 two year groups will be tested and vaccinated as a first step in this direction.

A lower overall immunity in childhood, such as is mentioned above does, however, call for greater vigilance when any cases of the disease occur, which might possibly have infected children. On two occasions during 1963 it was felt advisable to make quiet and unobtrusive Mantoux skin test surveys of groups of children thought possibly to have been at risk from a clinically detected case of tuberculosis. Both of these were reassuring, I am glad to say, and should rapidly have detected at an early stage any spread of infection which might conceivably have occurred.

I show below the usual data concerning the numbers offered Mantoux testing, etc., but I have omitted this year the

Year	No. offered Mantoux Test	No. of consents	% of consents	No. Mantoux tested	% tested of those offered	No. found positive	% found positive	No. given B.C.G.
1963	3,614	2,904	80	2,465	68	294	11.9	2,023
1962	3,766	2,968	79	2,665	71	356	13.3	2,206
1961	3,854	2,909	75	2,671	69	405	15.2	2,185

table detailing the figures by districts. In West Cumberland Dr. Hunter has recently been using the multiple puncture technique of Mantoux testing and he comments appreciatively on this as follows:—

" A fair saving in time of both doctors and nurses has been effected by dispensing with syringe and needle (and the cumbersome apparatus thereby entailed) in the sessions given to Mantoux testing of school children in large groups.

" The multiple puncture plate, one for each child, picked up by the magnetised head from a sterilized container of layers of such plates, takes very little time between cases. One point that has been noted in the application of this method is that the skin must be free from grease for the deposit by loop or glass rod of the testing fluid."

Protection against Diphtheria and Tetanus

The immunity index for diphtheria in the school population is estimated at 52 at the end of 1963. The corresponding figure for 1962 was 44. This figure is the percentage of school children whose immunity against the disease is reckoned to be adequate and up to date by agreed standards, viz., a primary protection or a reinforcement in the course of the last five years.

The numbers of school children immunised against diphtheria during the year were as follows:—

Primary course	1,789
Reinforcing injections	4,682

This improvement is gratifying and reflects the injection of additional effort in the schools in order to keep this highly important index rising.

With regard to tetanus protection, the numbers vaccinated in 1963 were as follows:—

Primary course	3,673
Reinforcing injections	2,504

This reflects a steadily rising community resistance against tetanus among young people—a matter of no little importance in our rural and agricultural environment. Firmly linked as this now is to diphtheria protection—indeed, the two will soon move forward exactly in parallel—its importance probably appeals a

little more in many cases to parents than does that of diphtheria immunity. The appeal in the latter case depends on convincing parents of the real risk of the re-appearance of epidemic diphtheria. Tetanus is, on the other hand, an ever present individual risk with scattered cases and fatalities constantly cropping up in the country and striking the public eye.

The regular and current notification to main hospitals and to general practitioners of children protected against tetanus continues systematically and I quote from the comments of Mr. Turney, Casualty Surgeon, West Cumberland Hospital, on the value of the scheme as far as he is concerned.

" May I thank you and your staff for enabling us to build and maintain this record of children who have been protected against tetanus.

" It has been of invaluable aid in the treatment of many, many cases, both here and at Workington and saved many a child from the second injection which the serum calls for, as well as saving parents and patients from the hour's wait which is also necessary when administering tetanus anti-toxin."

Most schools still require three visits in series each year by the medical officer to bring diphtheria and tetanus protection up to date. More of the children requiring a complete course of tetanus protection are now in the ten year old age group, however, since the majority of the school entrant children have received triple antigen in early childhood and simply require a single reinforcement covering both diphtheria and tetanus.

There is no doubt that pre-sterilised disposable syringes have come to stay as a feature of these programmes of immunisation. Their apparent value is in speed and efficiency, while the concealed advantage and ultimately the most important, lies in the assurance of complete sterility which they provide. This applies to serum transmitted hepatitis as well as to other possible infections. Criticism of some of this equipment during the year led to one of the medical officers visiting the factory of one of the main firms supplying syringes and reporting back on their latest improvements in manufacture and technique.

Protection against Poliomyelitis

The vaccination of the school child against poliomyelitis was simplified during 1963 by Ministry of Health Circular 10/63. This recommended that every child on entering school should receive a reinforcing dose of poliomyelitis vaccine. The complete recommended protection for a child according to present advice is, therefore, three doses of oral vaccine given between six and nine months of age and a fourth on school entry. It will be apparent that the aim must be to ensure that a full year group is reinforced in this way each year at entry to school.

The number of school children receiving reinforcing doses of poliomyelitis vaccine was 3,004, while 304 received primary courses.

By far the majority of those vaccinated against poliomyelitis now receive oral vaccine. A very few still receive Salk vaccine by injection and some general practitioners are using quadruple vaccine in a limited way. The latter, given by injection, protects young children against diphtheria, whooping cough, tetanus and poliomyelitis simultaneously. Important technical advantages with regard to the action of poliomyelitis vaccine still, however, lie with the Sabin oral material.

Infectious Diseases

I include this year again a table showing the incidence of the main infectious diseases in school children. Poliomyelitis and diphtheria are again absent from the list, a situation which only adequate immunisation will maintain. Measles continued at quite a high incidence in 1963 and whooping cough notifications rose to 57, particularly associated with a pocket of the disease in Workington. Here again, adequate immunisation in infancy is the best corrective. Notifications of food poisoning show a certain increase from last year and, while it is well known that recorded notifications of this disease do not present a complete picture of its occurrence, the increased figure occurs in a year in which further consideration has been given to this illness as it might arise in association with school feeding arrangements.

In the spring there was one short sharp outbreak of food poisoning associated with the preparation of a meat product in one of the school meals kitchens. The very high standard of hygiene obtaining in the school kitchens in the county undoubtedly prevents a great deal more such occurrences. In order, however, to provide the best and clearest guidance for the kitchen staffs, a series of meetings is at present being arranged at which a school medical officer will speak to groups of the staffs with a prepared concise code of kitchen hygiene as a basis of their discussion.

In reviewing the work in the schools, Dr. Ainsworth comments as follows on infectious conditions generally:—

"The only outbreak of infectious disease that has occurred in any school I have visited was scabies at one particular school. During the school medical inspection one mother asked me to look at her child's rash. This was clearly scabies which had been present unrecognised by the mother for about two months. On further enquiry it was clear that the same condition was shared by certain neighbours and other members of the family. Temporary exclusion of the child from school and a note to the family doctor ended the matter with no other cases appearing in the school. Only two cases of impetigo have been seen—one at a school clinic, the other in school. Both were referred to the family doctor for treatment. One isolated case of ringworm was encountered but was already under treatment."

Cases of Infectious Diseases in Children of School Age

	Scarlet Fever	Whooping Cough	Measles (excluding Rubella)	Dysentery	Meningococcal Infection	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	TOTAL
URBAN:											
Cockermouth	—	—	99	2	—	—	—	1	—	1	103
Keswick ...	—	—	—	—	—	—	—	—	—	—	—
Maryport ...	3	6	1	—	—	—	4	—	—	—	14
Penrith ...	2	3	61	—	—	—	—	—	—	—	66
Whitehaven...	2	7	70	—	—	—	—	1	—	—	80
Workington...	1	24	11	1	—	1	—	—	—	—	38
RURAL:											
Alston ...	—	—	—	—	—	—	—	—	—	—	—
Border ...	—	1	146	—	—	1	4	—	—	—	152
Cockermouth	1	4	50	2	—	—	2	2	—	—	61
Ennerdale ...	—	6	113	—	—	—	—	1	—	—	120
Millom ...	—	—	130	—	—	—	—	—	—	—	130
Penrith ...	—	5	137	5	—	1	6	—	—	—	154
Wigton ...	3	1	9	—	—	—	—	—	—	—	13
	12	57	827	10	—	3	16	5	—	1	931

No notifications were received in respect of poliomyelitis, diphtheria and smallpox.

Swimming Baths

No new school swimming pools have, in fact, come into use during 1963, although those in use have been followed up from the hygiene point of view and have, in the main, given very satisfactory results.

I discussed briefly in my report last year some of the puzzling difficulties which had arisen about the water at the pool at Solway School, Maryport. I expressed the view then that it seemed likely that it would be necessary to reconsider the ten hour turnover period of the water provided by the present plant. It has, in fact, now been decided that a larger filtration plant is necessary in this pool and I am confident that the anomalies in testing and the unsatisfactory water sampling in the past should be overcome by this more radical measure. Consistently satisfactory samples were still not obtainable even after further adjustments of the purification and filtration procedures.

Samples taken from the Purley pool at St. Andrew's School, Penrith, were all satisfactory. School children in Penrith, however, also bathe in the River Eamont, and here in some cases water sampling was less satisfactory, with the bacteriological result approaching nearer to the recommended danger level for river water than is desirable. This may well be associated with a degree of sewage contamination rather than with any other fault in the water. Dr. Smith reports that a more intensive study of the water in the River Eamont is planned in the present year in consultation with Penrith Swimming Club. Dr. Smith also reports that at Wigton the baths which are used by all the schools and also by the public at certain times give satisfactory sampling results.

From Millom R.D. Dr. Crowley reports as follows:—

"Millom Comprehensive School and Seascale Primary School are each equipped with a swimming pool. This is a matter of some satisfaction because otherwise a large percentage of pupils would never learn to swim. This may sound paradoxical in a seaside area of this kind but the nature of the shores around here do not lend themselves to stimulate the desire to swim as opposed to bathing.

"The hygienic state of both baths has been followed closely. They are new structures and kept in a good state of cleanliness. Bacteriological samples taken from the Seascale swimming pool have been uniformly satisfactory. However, a sample taken from the Millom swimming pool on 28th June was reported on as not quite satisfactory, showing 100 colonies per ml. at 37°C. on the Agar Plate. As a result of this, chlorination was stepped up and further samples were quite satisfactory. Both swimming pools opened after the Easter holidays and officially close at the end of summer term. However, the weather being suitable, swimming is allowed up to about September."

HEALTH EDUCATION

The School Health Service has continued to expand its activities in the field of health education. Eighteen new film-strips have been bought, three new projectors and many hundreds of leaflets and posters in an effort to meet the ever-changing needs of the school community. The total number of projectors in constant use in the county is now twelve, these being placed at strategic centres to enable all the members of staff to obtain one quickly and avoid both waiting lists and time and mileage. There is an ever-increasing demand for health visitors and school nurses to give talks. These are always supported by film-strips, leaflets and flannelgraphs, many nurses making their own flannelgraphs. Probably the most popular talks are those on general health subjects and, secondly, those on prevention of disease. Mothercraft is a constant favourite, and as health education is usually taught in secondary modern schools, it is felt that this is of special value. The emphasis has rather changed; whereas a few years ago the nurses and health visitors were talking about " care of the hair," now the children are more interested in the total needs of a baby, and the normal child development. Here it is obvious that something can be done to raise the standards of living for the next generation. While moral standards and sex education are not taught in schools as such, the need for a baby to have both mother and father love, and discipline is stressed, and the type of home environment in which a child thrives best.

One school nurse/health visitor reports that—" Last week I had four of the class (lower stream) to attend the Child Welfare Clinic with me to see what happened there. They helped with the cards, showed mothers and babies through to doctor and all listened to my talk to the mothers on Home Safety with flannelgraphs, flame-proof nightwear samples, etc. They were very interested and enjoyed the clinic. This, I hope, will encourage them as young mothers to come along to the clinics."

Smoking and Health

Great prominence has been given to the connection between smoking and lung cancer and a film has been obtained during the last year called " Smoking and You." This film has been used extensively both in schools and youth centres.

The comments of some of the head masters following the showing of this film might be interesting—" The impression I gained was that the film made a great impact on the junior more than on the senior classes." A headmistress reports—" Everyone was most interested, as evidenced by the large number of sensible and thoughtful questions asked of the school doctor afterwards. Whether seeing the film will influence any of them to be non-smokers, I do not know, but I think those who are already forming the habit of smoking to be somewhere about half a dozen at the most. However, a great many more than this say they are determined to be non-smokers." A tutor of a further education centre writes—" My observations on the reactions of children are necessarily subjective, but I would say that the film had considerable impact on the children who are not yet habitual smokers but was fairly rapidly shrugged off by those children who do smoke." The film was followed by questions and the defensive nature of these questions was much in evidence in some schools—" Was it safe to smoke only a few cigarettes?" " What about tipped cigarettes?" " What about only taking a few puffs and then putting it out later?" One headmaster commented—" Obviously many of the boys had given a great deal of thought to this social problem and I am sure the film had a most beneficial effect." " We have had much less trouble with smoking since the film was shown but this may merely mean that it has been driven further underground."

Dr. Dobson makes the following comments on the visit of the mobile unit of the Central Council for Health Education.

" The department's campaign against smoking was supplemented for two weeks in November by the use of one of the Central Council for Health Education's Mobile Units. A unit consists of a mini-van carrying health education material and apparatus and is staffed by two lecturers who work as a team. They are equipped and trained to use all the familiar resources of health education in a variety of situations, whether in clinics or clubs, schools or sponsored meetings. Following the pattern suggested by the Central Council it was decided in one of the two weeks spent in West Cumberland to concentrate on junior classes in secondary schools.

" The technique, in brief, was to stick to single classes rather than talk to large audiences. Thus, fewer schools could be

visited but more pupil participation secured. A talk, illustrated by a sound film or flannelgraphs was given first, and generous time allowed for discussion subsequently.

" I attended two of these sessions, they really went very well. The talk was down to earth and presented the subject so that it captured interest without fertilising anxieties; but, nevertheless, made the dangers of smoking plain enough. These sessions have probably made a real impact on some children. But the seeds of firm belief in the advisability of keeping off smoking are few in a very large field.

" The recommended practice is to follow up these talks with reminder or refresher talks at intervals, though it is not possible to assess objectively the value of health education on these lines. In any case there is a shortage of people with the necessary training for this work and the evangelical enthusiasm which is surely required to carry conviction."

It is apparent from the above comments and accounts that there is an ear for health education directed against the cigarette smoking habit in schools. This is so far encouraging because there can be no doubt that it is in the younger secondary school child (and, perhaps, in some cases in the older junior school child) that the most rewarding work can be expected in this singularly intractable problem.

The next move is, I believe, to secure child participation in the campaign against the smoking habit in schools. I hope next year to be able to report some progress in this direction, as well as the maintenance of the present measures. Undoubtedly, the purchase of the film " Smoking and You " has already proved a worthwhile investment.

RELATED SERVICES

Medical Examination of Teachers

The following medical examinations took place during the year:—

Entrants to Training Colleges ...	152
Entrants to employment as teachers by Cumberland Education Committee ...	141

During the latter part of the year a pilot scheme was introduced whereby a candidate for a teaching appointment only completes a questionnaire as well as submitting a satisfactory chest X-ray report which is less than twelve months old. From the questionnaire it is assessed whether a medical examination is necessary. At the time of writing this report this procedure is working quite satisfactorily, but longer term assessment will, of course, be more significant. Medical examinations continue to be carried out as before for certain senior teaching posts.

School Premises

Mr. Gordon S. Bessey, Director of Education, has supplied the following note on developments in regard to school premises:—

"During this year temporary additional accommodation was provided at Cockermouth and Whitehaven Grammar Schools, Overend and Victoria Secondary Schools and the Whitehaven Valley Junior School. Additional permanent accommodation was provided at Millom and Silloth Secondary Schools. The new premises for Thursby School were completed and Oulton C. of E. School was remodelled.

"The managers of Maryport R.C. and Scotby C. of E. Schools provided new premises for the schools and the managers of Calthwaite C. of E. and Wiggonby C. of E. Schools remodelled the schools."

I mentioned in last year's report the fact that discussions were taking place with the Director of Education's staff about certain schools whose sanitary conditions in terms of toilet and washing facilities were giving me some concern. Two meetings have taken place since then, at which a considerable list of schools was discussed and minimum improvements agreed, especially where the life of the school was short in any case.

More extensive work was agreed upon for certain other schools which still have a reasonable life span. I am glad to be able to report that arising out of these meetings considerable improvements have been made, leaving only a few instances where conditions are still less than adequate.

School Meals

Mr. Bessey has also supplied the following report on the School Meals Service, together with the note on Milk in Schools, which follows:—

" During 1963 a hot midday meal was again available for children in attendance at each of the authority's 280 nursery, primary and secondary schools and again, following the trend established during the past few years, the percentages of children taking dinners at both primary (including nursery) and secondary schools on a day in September showed appreciable increases, while the overall percentage at all schools attained its highest figure ever, namely 76%. The figures for that day, as compared with those for a day in September, 1962, are set out below:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals
1963	20,577	14,691	71.4	14,815	12,203	82.4	35,392	26,894	76.0
1962	20,353	13,708	67.4	14,996	12,041	80.3	35,349	25,749	72.8

" Some new buildings, as well as adaptations and improvements to existing premises, were completed during the year and, as a result, the number of kitchens (including central kitchens) in use at the end of the Autumn term had risen to 120.

" Included in the new St. Patrick's R.C. School at Maryport is a 150 meals kitchen which began to produce dinners on 24th June. Previously, children in attendance at this school had dined in the old school premises, meals having been sent from Maryport Central Kitchen.

" A first instalment of the new St. Mary's R.C. School at Harrington opened on 28th October and a kitchen, to produce 100 meals daily, was taken into use on that date. This provision is a tremendous improvement on the former dining

arrangements at the Y.M.C.A. rooms, since there the accommodation was shared with Harrington Junior School and the meals were sent from Stainburn Central Kitchen.

" Although work still continues on the adaptation and extension of St. Joseph's R.C. Secondary School at Workington, a new 350 meals kitchen opened on 29th April and produces dinners for that school only. The Junior School are now the sole occupiers of the dining accommodation which they formerly shared with the secondary school pupils and their dinners continue to be drawn from Stainburn Central Kitchen.

" Extensions and rehabilitation schemes were completed at two small rural schools, namely, Oulton C. of E. and Wiggonby C. of E. and, in each case, a forty meals kitchen was provided. Oulton opened on 24th April, thereby superseding the previously existing dining arrangements in the Village Institute, while the kitchen at Wiggonby School was taken into use on 8th July. Both schools had previously obtained meals from Wigton Central Kitchen.

" For some time the two existing kitchens at Millom School have been producing dinners far in excess of their rated capacity in an effort to cope with the increasing demand for meals at this growing school and, latterly, it had been necessary for some pupils to take their midday meal in the dining room at the nearby Central Kitchen. It was with a sense of relief, therefore, that the school took into use on 10th September, an additional 250 meals kitchen and appropriate dining space.

" While it has been necessary to persevere for a number of years with a very much sub-standard kitchen and dining room in rented premises at Waberthwaite, our patience was rewarded by the opening, on 28th October, of a new forty meals kitchen at Waberthwaite C. of E. School. The meal is taken in an adjoining classroom and in the assembly hall.

" A much needed improvement at Lazonby C. of E. School was effected by the adaptation of a H.O.R.S.A. classroom to form a forty meals kitchen and dining room; these were taken into use on 20th May.

" The amalgamation of Broughton Junior and Infants' Schools to form Broughton Primary School freed sufficient space in the combined school premises to enable a cloakroom to be adapted to form a scullery and a classroom to be used for dining purposes. Similarly, the opportunity was taken to

adapt a small room at Broughton School to form a scullery, thus enabling dinners to be served in an adjoining room. In both cases the introduction of the service of the meal into the school itself, enabled the use of rented premises for this purpose to be dispensed with.

" Minor adaptations were undertaken to a former housecraft room at Cleator County School (which was already in use for dining purposes) so as to provide a scullery and to improve dining conditions.

" Since the eating of meals in a classroom at Hutton Roof C. of E. School was proving inconvenient and washing up in a cloakroom was giving rise to overcrowding, an approach was made to the local Women's Club for the use of their premises and, suitable terms having been agreed, the Women's Club room and scullery were taken into use on 11th June.

" The adaptation and extension of Calthwaite C. of E. School resulted in the temporary transfer of the Calthwaite children to Hutton End Village Hall from 24th April, in consequence of which Hutton Marr School was no longer able to use these premises as dining and scullery accommodation. However, it is likely that Calthwaite School will be returning to its own re-modelled premises (which will include a forty meals kitchen) during the Spring term, 1964, when Hutton Marr School will then be able to revert to their former meals arrangements.

" The Education Committee were obliged to vacate Christ Church Parish Rooms, Penrith, at the end of the Summer term, having received notice to do so from the landlords, but were fortunate in securing alternative dining and washing up accommodation in Wordsworth Street Rooms for the service of dinners to children in attendance at National C. of E. Infants' and Robinson's Infants' Schools, Penrith.

" The screening off of the scullery from the rest of the dining area in the South Watt Street premises at Workington, which are rented by the Education Committee for use by St. Patrick's R.C. Junior School, resulted in a worthwhile improvement in dining conditions.

" An important advance by the School Meals Service in 1963 has been the introduction at several secondary schools of alternative dishes for the midday meal. In practice, this usually involves offering two alternatives for the first course and two

for the second, although in some schools more than two alternatives at each course are regularly available. By December a choice of menu was offered at the following schools:—

Irthing Valley, Brampton.
Lillyhall, Distington.
Tynefield, Penrith.
Ullswater, Penrith.
Workington Grammar.
St. Joseph's R.C. Secondary, Workington.
Salterbeck, Workington.

"At the beginning of the year a choice of menu was offered only at Salterbeck School.

"Experience so far has shown that choice of menu has considerable advantages:—

(*a*) The children like it. A choice in food has for a long time been regarded as a privilege of adults. For children, it is a sound preparation for adult life to learn how to exercise this choice responsibility while still at school. For some children the opportunity to exercise choice has transformed their whole attitude to the school meal.

(*b*) Kitchen staff like it. Their work is given greater interest and variety and they are brought into closer contact with the children.

The appreciation of the children is a considerable encouragement for kitchen staff. Choice of menu also permits limited experiments with new dishes which could not otherwise be tried out.

(*c*) The number of teaching staff taking school meals has increased.

(*d*) Kitchen waste has been greatly reduced.

"It is hoped that soon all secondary schools in Cumberland will offer a choice of menu for their school meal.

Milk in Schools

"The figures given below show the consumption of milk by day pupils present in the 280 nursery, primary and secondary schools maintained by the Authority on a day in September, 1963, as compared with a day in the same month in 1962:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk
1963	20,577	18,841	91.6	14,815	8,610	58.1	35,392	27,451	77.6
1962	20,353	18,508	90.9	14,996	8,389	55.9	35,349	26,897	76.1

" While it is gratifying to note an advance in the overall percentage of children taking milk, it is particularly pleasing that the trend towards increased milk drinking in secondary schools, which first became apparent last year after a marked decline in previous years, has been maintained.

" The following table shows the percentages of different types of milk being supplied to day children attending maintained schools in September, 1963. Corresponding figures for 1962 are shown in brackets:—

Pasteurised (including pasteurised T.T.) 84.7% (80.9%)
Tuberculin Tested (non-pasteurised)... 15.3% (19.1%)"

Physical Education

After long and valued service the Chief Woman Organiser of Physical Education, Miss K. Sutton, and her sister, the Assistant Woman Organiser of Physical Education, Miss M. Sutton, retired from the county staff in September, carrying with them the good wishes of the Authority, the teachers and the children of Cumberland. Untiring in their efforts and unsparing in their time and energy for the physical well-being of the children, they will be greatly missed in the schools and in the field of voluntary activity in the county where their enthusiasm and help were much appreciated.

Miss E. C. McKelvie, of the Department of Physical Education of Leeds University, will be most welcome to Cumberland when she assumes her duties in April as Chief Woman Organiser of Physical Education.

As they move into an adult world young people find themselves faced with conditions which demand adaptability, foresight, self-reliance, courage and patience. Our schools, youth clubs and colleges must give full play to the generous impulses of youth and their contributions must be positive in sending out young men and women who are eager and competent to give a constructive service to a world of automation, industrial

strife and economic competition, where the individual is in danger of being engulfed in the maelstrom of the might of the mass of others.

The development and preservation of individuality and the adaptability of the human mind and body to changing circumstances is an educational process to which physical education has a large contribution to make. The unfolding of this process begins in the primary school where the child gains skill and confidence in basic techniques of movement in its many forms, together with agility, strengthening and sports skills, so that he is receptive to positive guidance in the widening spectrum of activity of the secondary school. At this latter level physical activity, according to personal requirements, is presented in variety and later in depth to meet individual needs, personal choice in physical recreation playing an important part in the selection of programmes. The final link with adult life is forged through the youth service and further education centres, where the opportunities for young people to continue training and to widen further their interests in physical and social recreation are constantly being encouraged.

Much of the social training of apprenticed citizens is undertaken outside the confines of the school building—on the playing fields and in the countryside. Cumberland teachers are to be complimented upon the active part they play through voluntary associations in voluntary school, inter-school, inter-district and inter-county events arranged in the evenings, at week-ends and during holiday periods.

In spite of the severe weather of 1963 the Cumberland Schools' Football Association completed its usual programme. The Cumberland Schools' Athletic Association held its annual Cross Country Championships at Penrith in the snows of March when twenty-four boys were selected to represent the county at the National Championships at Coventry; in the County Sports at Carlisle H. Jeffrey was selected to represent England in the 120 yards Hurdles at Edinburgh on 27th July; the Cumberland Schools' Badminton Association held its first championships meeting at Whitehaven in March. The Cumberland Schools' Cricket Association followed its annual programme; the Cumberland Schools' Gymnastic Association, formed in 1962, arranged its first inter-county match against Durham in March and the second Gymnastic Championships

at Lillyhall in December. The schools' section of the Cumberland Netball Association, after reorganising the Annual Secondary Schools' Tournament on account of the large entry were obliged to abandon the finals to be held at Keswick in March; the senior section held its club tournament in July for ten teams from factories, offices, youth clubs and Young Farmers' Clubs; county fixtures were arranged against Northumberland and West Riding and the team attended the North Western Territorial Tournament at Carnforth.

Both the Junior and Senior Sections of the Cumberland Women's Hockey Association were restricted this year by the severe weather. The Cumberland Schools' Swimming Association held its Inter-Town Gala at Wigton Baths in July; ten swimmers were selected to represent Cumberland at the Divisional Gala at Liverpool in September and three competitors went forward to the National Gala at Bournemouth in October. The Cumberland and Westmorland Schools' Rugby Union arranged day coaching courses in September at Maryport, Carlisle, Workington and Kendal for the Under 15 group. The Cumberland Schools' Rugby League has maintained its annual programme of county matches and coaching courses. The Cumberland Schools' Sailing Association has been formed to meet the growing demand for this sport in secondary schools. It is based on Scarness where there are a store hut, toilets, a motor safety boat and a jetty. A fleet of six cadets, built by schools, is used by sixteen schools who form the initial membership of the Association. In the field of adult recreation the Cumberland Judo Association has been inaugurated and forms a Sub-Committee of the Northern Area B.J.A. Grading sessions and courses for members and leaders have been arranged through the Association, using the National Coach, Harry Marr. Training courses for teachers and leaders have been held in athletics (pole vault, hammer and triple jump), rugby, ski-ing, snow and ice, rock-climbing, canoe handling, sailing, life saving (the expired air method), judo and fencing.

Through the facilities now available at our Centres it is possible to offer on a county basis classes in angling, archery, athletics, swimming and life-saving, fencing, judo, wrestling, badminton, basketball, netball, all forms of dancing, recreational gymnastics, women's " keep-fit," football, rugby, cricket, golf, rock-climbing, ski-ing, canoe and boat building, sailing, weight

training and general fitness training. It is pleasing to report that the new Wyndham School and Centre, now under construction, will be able to offer this breadth of activity to its pupils and students, while the Moorclose Secondary School will be able to arrange parallel programmes in the future. Where it has been possible to prepare comprehensive jumping facilities, teachers and leaders have been greatly encouraged by the general improvement in athletic field events; the all-weather surfacing at Workington has made games training possible under extreme adverse conditions when grass pitches would be unusable for many weeks; the improvements in drainage at Millom, Alston, Cleator Moor, Derwent, Salterbeck, Brampton and Wigton Schools have widened considerably hitherto restricted organised games training, and the gradual expansion of maintained playing fields to 420 acres is reflected in the improvement in the standard of play among pupils in Cumberland schools. With the facilities now available to them, both natural and constructed, and with training and encouragement from teachers and leaders, young people in Cumberland have every opportunity of equipping themselves to be of service to the community.

APPENDIX A

MEDICAL INSPECTION AND TREATMENT

Part 1—Medical Inspection of Pupils attending maintained Primary and Secondary Schools (including Nursery and Special Schools)

Table A—Periodic Medical Inspections

Age Groups inspected (By year of Birth) (1)	No. of Pupils Inspected (2)	PHYSICAL CONDITION OF PUPILS INSPECTED				Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory		Unsatisfactory		For defective vision (excluding squint) (7)	For any other condition recorded at Part II (8)	Total Individual pupils (9)
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)			
1959 and later	40	40	100	—	—	—	2	1
1958	1275	1272	99.76	3	0.24	54	92	139
1957	1915	1914	99.94	1	0.06	93	131	210
1956	155	155	100	—	—	6	7	13
1955	48	48	100	—	—	3	1	4
1954	31	31	100	—	—	2	—	2
1953	2029	2029	100	—	—	89	126	212
1952	133	133	100	—	—	9	7	16
1951	65	65	100	—	—	6	10	16
1950	24	24	100	—	—	1	—	1
1949	2962	2960	99.93	2	0.07	142	103	243
1948 and earlier	188	188	100	—	—	9	5	14
TOTAL	8865	8859	99.93	6	0.07	414	484	871

Table B—Other Inspections

Number of Special Inspections ...	4,359
Number of Re-inspections	7,188
Total ...	11,547

Table C—Infestation with Vermin

(*a*) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	95,817
(*b*) Total number of individual pupils found to be infested	1,419
(*c*) Number of individual pupils in respect of whom cleansing notices were issued (Section 54 (2), Education Act, 1944)	1
(*d*) Number of individual pupils in respect of whom cleansing orders were issued (Section 54 (3), Education Act, 1944)	—

Table D—Screening Tests of Vision and Hearing

1. (*a*) Is the vision of entrants tested?...	Yes.
(*b*) If so, how soon after entry is this done? ...	Within 12 months.
2. If the vision of entrants is not tested, at what age is the first vision test carried out?	——
3. How frequently is vision testing repeated throughout a child's school life?	Entrant, 8 yrs., Intermediate, Leaver.
4. (*a*) Is colour vision testing undertaken?	No (only if suggested for special reason).
(*b*) If so, at what age?	——
(*c*) Are both boys and girls tested?	——
5. By whom is vision and colour testing carried out?	School medical officers and school nurses.
6. (*a*) Is audiometric testing of entrants carried out? ...	Yes.
(*b*) If so, how soon after entry is this done? ...	Within 12 months.
7. If the hearing of entrants is not tested, at what age is the first audiometric test carried out? ...	——
8. By whom is audiometric testing carried out? ...	Audiometrician.

Part II—Defects found by Medical Inspection during the year

Table A—Periodic Inspections

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS Entrants (T)	Entrants (O)	Leavers (T)	Leavers (O)	Others (T)	Others (O)	Total (T)	Total (O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4	Skin	21	104	28	112	28	96	77	312
5	Eyes—a. Vision ...	147	394	142	545	125	395	414	1334
	b. Squint ...	20	50	6	29	3	54	29	133
	c. Other ...	5	17	4	23	5	13	14	53
6	Ears—a. Hearing ...	18	160	14	42	17	40	49	242
	b. Otitis Media	4	43	2	15	3	26	9	84
	c. Other ...	2	28	1	10	1	15	4	53
7	Nose and Throat ...	39	331	6	84	11	144	56	559
8	Speech	36	92	4	16	14	39	54	147
9	Lymphatic Glands...	9	106	—	22	2	18	11	146
10	Heart	1	61	2	31	2	41	5	133
11	Lungs	4	133	1	54	—	88	5	275
12	Developmental—								
	a. Hernia ...	3	18	5	6	1	4	9	28
	b. Other ...	3	53	—	15	1	73	4	141
13	Orthopaedic—								
	a. Posture ...	2	10	6	11	6	22	14	43
	b. Feet ...	30	129	12	103	31	90	73	322
	c. Other ...	23	207	11	117	16	100	50	424
14	Nervous System—								
	a. Epilepsy ...	—	10	—	15	—	10	—	35
	b. Other ...	4	18	1	16	1	14	6	48
15	Psychological—								
	a. Development	5	22	1	32	1	57	7	111
	b. Stability ...	5	77	—	26	7	69	12	172
16	Abdomen	—	42	—	20	3	40	3	102
17	Other	2	60	2	68	4	55	8	183

Table B—Special Inspections

Defect Code No.	Defect or Disease	SPECIAL INSPECTIONS Pupils requiring Treatment	Pupils requiring Observation
(1)	(2)	(3)	(4)
4	Skin	142	36
5	Eyes—a. Vision ...	242	411
	b. Squint ...	4	12
	c. Other ...	13	18
6	Ears—a. Hearing ...	57	114
	b. Otitis Media	5	14
	c. Other ...	5	6
7	Nose and Throat ...	45	76
8	Speech	30	27
9	Lymphatic Glands ...	3	12
10	Heart	3	15
11	Lungs	7	43
12	Developmental—		
	a. Hernia ...	—	3
	b. Other ...	1	10
13	Orthopaedic—		
	a. Posture ...	—	3
	b. Feet ...	23	22
	c. Other ...	14	41
14	Nervous System—		
	a. Epilepsy ...	1	6
	b. Other ...	1	8
15	Psychological—		
	a. Development	12	29
	b. Stability ...	11	37
16	Abdomen	7	28
17	Other	55	93

Part III—Treatment of Pupils attending maintained Primary and Secondary Schools (including Nursery and Special Schools)

Table A—Eye Diseases, Defective Vision and Squint

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	5
Errors of refraction (including squint)...	3,533
Total	3,538
Number of pupils for whom spectacles were prescribed	1,626

Table B—Diseases and Defects of Ear, Nose and Throat

	Number of cases known to have been dealt with
Received operative treatment—	
(*a*) for diseases of the ear ...	4
(*b*) for adenoids and chronic tonsillitis	70
(*c*) for other nose and throat conditions	19
Received other forms of treatment ...	29
Total	132
Total number of pupils in schools who are known to have been provided with hearing aids—	
(*a*) in 1963	13
(*b*) in previous years	32

Table C—Orthopaedic and Postural Defects

	Number of cases known to have been treated
(*a*) Pupils treated at clinics or out-patients departments	1,174
(*b*) Pupils treated at school for postural defects	—
Total	1,174

Table D—Diseases of the Skin

(excluding uncleanliness, for which see Table C of Part I)

	Number of cases known to have been treated
Ringworm—(*a*) Scalp	—
(*b*) Body	16
Scabies	4
Impetigo	19
Other skin diseases	180
Total	219

Table E—Child Guidance Treatment

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	448

Table F—Speech Therapy

	Number of cases known to have been treated
Pupils treated by speech therapists ...	473

Table G—Other Treatment Given

	Number of cases known to have been dealt with
(*a*) Pupils with minor ailments ...	63
(*b*) Pupils who received convalescent treatment under School Health Service arrangements	95
(*c*) Pupils who received B.C.G. vaccination	2023
(*d*) Other than (*a*), (*b*) and (*c*) above	—
Total (*a*)—(*d*) ...	2,181

Part IV—Dental Inspection and Treatment carried out by the Authority

(a) Dental and Orthodontic work:

(1)	Number of pupils inspected by the Authority's Dental Officers:—			
	(*a*) At Periodic Inspections	28,933		
	(*b*) As Specials	203		
			Total	29,136
(2)	Number found to require treatment			17,205
(3)	Number offered treatment... ...			12,590
(4)	Number actually treated			11,735

(b) Dental Work (other than orthodontics):

(1)	Number of attendances made by pupils for treatment, excluding those recorded at (*c*) 1 below ...			28,192
(2)	Half days devoted to:			
	(*a*) Periodic (School) Inspections	291		
	(*b*) Treatment	3,721		
			Total	4,012
(3)	Fillings:			
	(*a*) Permanent Teeth ...	15,280		
	(*b*) Temporary Teeth ...	1,685		
			Total	16,965

(4)	Number of Teeth filled:			
	(*a*) Permanent Teeth ...	13,946		
	(*b*) Temporary Teeth ...	1,634		
			Total	15,580
(5)	Extractions:			
	(*a*) Permanent Teeth ...	6,170		
	(*b*) Temporary Teeth ...	11,762		
			Total	17,932
(6)	(*a*) Number of general anaesthetics given for extractions			4,122
	(*b*) Number of half days devoted to the administration of general anaesthetics by:			
	Dentists	290		
	General Practitioners	—		
			Total	290
(7)	Number of pupils supplied with artificial teeth			373
(8)	Other operations:			
	Crowns	10		
	Inlays	41		
	Other treatment ...	7,630		
			Total	7,681

(c) Orthodontics:

(1)	Number of attendances made by pupils for orthodontic treatment...	1,030
(2)	Half days devoted to orthodontic treatment	84
(3)	Cases commenced during the year	332
(4)	Cases brought forward from the previous year	133
(5)	Cases completed during the year	74
(6)	Cases discontinued during the year	29
(7)	Number of pupils treated by means of appliances	139
(8)	Number of removable appliances fitted	133
(9)	Number of fixed appliances fitted	2
(10)	Cases referred to and treated by Hospital Orthodontists	387

APPENDIX B

Handicapped Pupils requiring Education at Special Schools approved under Section 9(5) of the Education Act, 1944, or Boarding in Boarding Homes.

During the calendar year ended 31st December, 1963	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes?	1	2	1	—	1	1	—	35	—	—	41
B. (i) of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	—	—	—	—	—	—	1	—	—	1
(ii) of the children assessed prior to 1st January, 1963, how many were newly placed in special schools (other than hospital special schools) or boarding homes?	—	—	1	—	1	—	—	11	—	—	13
Total B(i) and B(ii) ...	—	—	1	—	1	—	—	12	—	—	14

During the calendar year ended 31st December, 1963	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
On 23rd January, 1964, how many handicapped pupils from the Authority's area:—											
C. (i) were requiring places in special schools—Total (a) day ...	—	—	—	—	—	—	—	48	—	—	48
(b) boarding ...	2	3	1	1	4	1	—	127	1	—	140
(ii) included at (i) had not reached the age of 5 and were awaiting (a) day places	—	—	—	—	—	—	—	—	—	—	—
(b) boarding places	—	—	1	—	1	—	—	—	—	—	2
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting—											
(a) day places	—	—	—	—	—	—	—	15	—	—	15
(b) boarding places	1	—	—	1	1	—	—	48	—	—	51
D. (i) were on the registers of (1) maintained special schools as—											
(a) day pupils	—	—	—	—	—	—	—	2	—	—	2
(b) boarding pupils	—	2	1	—	2	—	—	82	—	—	87

(2) non-maintained special schools as—												
(a) day pupils	—	—	—	—	—	—	—	—	—	—	—
(b) boarding pupils	7	1	11	8	8	1	—	—	2	—	38
(ii) were on the registers of independent schools under arrangements made by the Authority	—	—	—	—	3	—	—	1	—	—	4
Total D(i) and D(ii) ...	7	3	12	8	13	1	—	85	2	—	131
(iii) were boarded in homes and not already included under (i) and (ii) above	—	—	—	—	—	—	—	—	—	—	—
Total [D(i), (ii) and (iii)]...	7	3	12	8	13	1	—	85	2	—	131
E. On or about 23rd January, 1964, how many handicapped pupils (irrespective of the areas to which they belong) were being educated under arrangements made by the Authority in accordance with Section 56 of the Education Act, 1944											
(i) in hospitals	—	—	—	—	10	—	—	—	—	—	10
(ii) in other groups (e.g., units for spastics, convalescent homes)	—	—	—	—	—	—	—	—	—	—	—
(iii) at home	2	—	—	—	11	—	—	1	—	—	14

APPENDIX C

SCHOOL HEALTH SERVICE CLINICS AS AT 31.12.63

(Actual school clinic work as distinct from special clinics is being carried out either in conjunction with child welfare clinic sessions or as specially required).

ALSTON:

Dental—2nd and 4th Tuesdays—all day.

ASPATRIA:

Dental—Each Monday—all day.
Orthopaedic Aftercare—2nd Friday p.m., 4th Friday a.m.
Speech Therapy—Each Thursday p.m.

BRAMPTON:

Dental—Each Tuesday, Wednesday and Thursday—all day.
Orthopaedic Aftercare—1st Tuesday a.m.

CARLISLE:

Dental—daily—all day.
At Eden and Caldew Schools alternate Mondays.
Eye Specialist—Each Monday and Thursday a.m.
Orthoptic—Each Tuesday a.m.
E.N.T. Specialist—Monday p.m. as required.
Child Guidance—Each Thursday p.m.
Speech Therapy—All day Tuesday and Friday p.m.
Orthopaedic Aftercare—Each Tuesday p.m.
Orthopaedic Surgeon—1st Monday every odd month p.m.; 1st Monday every fourth month a.m. and occasionally as required.

CLEATOR MOOR:

Dental—Each Tuesday and Friday—all day.
Orthopaedic Aftercare—1st and 3rd Tuesdays p.m.
Speech Therapy—Each Tuesday a.m.

COCKERMOUTH:

Dental—Each Monday, Tuesday and Wednesday—all day.
At Derwent School—each Friday—all day.
Eye Specialist—Each Tuesday a.m., except 4th Tuesday.
Orthopaedic Aftercare—1st and 3rd Wednesday—all day.
Speech Therapy—Each Thursday—all day.

EGREMONT:

Dental—Each Monday—all day.
Speech Therapy—Each Wednesday a.m.
Orthopaedic Aftercare—1st and 3rd Tuesdays a.m.

FRIZINGTON:

Dental—Each Wednesday—all day.

KESWICK:

Dental—Each Thursday—all day.
Speech Therapy—Each Tuesday p.m.
Orthopaedic Aftercare—4th Monday—all day.
Eye Specialist—Each 4th Tuesday a.m.

LONGTOWN:

Dental—Each Friday—all day.

MARYPORT:

Dental—Each Monday, Tuesday, Thursday and Friday —all day.
Speech Therapy—Each Monday a.m. and each Wednesday —all day.
Orthopaedic Aftercare—2nd and 4th Tuesday—all day.
Child Guidance—Each Monday p.m.

MILLOM:

Dental—Each Monday, Tuesday and Wednesday—all day.
Millom Comprehensive School—Each Friday—all day.
Speech Therapy—Each Thursday—all day.
Child Guidance—Thursday p.m. as required.
Orthopaedic Aftercare—3rd Monday a.m.
Eye Specialist—1st and 3rd Friday a.m.

PENRITH:

Dental—1st, 3rd and 5th Tuesday; each Wednesday, Thursday and Friday—all day.
Speech Therapy—Tuesday a.m.; Wednesday—all day.
Orthopaedic Aftercare—2nd and 4th Wednesday—all day.
Orthopaedic Surgeon—1st Monday every fourth month p.m.

SEASCALE:

Dental—Each Thursday—all day.
Orthopaedic Aftercare—3rd Monday p.m.

SILLOTH:

Dental—Each Wednesday—all day.
Orthopaedic Aftercare—3rd Friday p.m.

WHITEHAVEN (FLATT WALKS):

Dental—Daily—all day. 2nd clinic—Wednesday—all day.
School—Daily a.m. with medical officer attending each Wednesday morning.
E.N.T. Specialist—Tuesday a.m. as required.
Eye Specialist—Each Monday, Wednesday and Thursday a.m.
Speech Therapy—Monday and Friday—all day.
Orthopaedic Aftercare—Each Thursday—all day.
Orthopaedic Surgeon—1st Friday every odd month a.m.; 2nd Friday every even month a.m. and occasionally as required.
Child Guidance—Each Wednesday p.m. Each Friday a.m.

WHITEHAVEN (MIREHOUSE):

Dental—Thursday—all day.

WIGTON:

Dental—Each Tuesday, Wednesday and Thursday—all day.
Speech Therapy—Each Thursday a.m.
Orthopaedic Aftercare—3rd Friday a.m.

WORKINGTON (STONELEIGH):

Dental—Daily—all day.

WORKINGTON (PARK LANE):

Dental—Each Tuesday and Friday.
School—Daily a.m. with medical officer attending each Tuesday a.m.
Speech Therapy—Each Monday and Friday—all day.
Orthopaedic Aftercare—Each Friday p.m. and 2nd and 4th Friday a.m.
Orthopaedic Surgeon—1st Friday every even month a.m.; 2nd Friday every odd month a.m. and occasionally as required.
Eye Specialist—Each Thursday a.m.
Child Guidance—Each Wednesday a.m.